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This study was conducted to determine the optimum method of using reserve component medical personnel during annual training. A survey was given to selected individuals in the reserve component and the active component. The survey measured attitudes about training and usage of reserve component personnel during annual training. The survey identified a large number of shortcomings in the present system. The author discussed the advantages and disadvantages of each problem.

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# A STUDY OF HOW RESERVE COMPONENT ASSETS CAN BE BETTER UTILIZED IN ORDER TO OPTIMIZE THE MISSION CAPABILITIES OF ACTIVE COMPONENT ARMY MEDICAL DEPARTMENT TREATMENT FACILITIES AND AT THE SAME TIME OPTIMIZE THE INDIVIDUAL AND COLLECTIVE TRAINING RECEIVED BY RESERVE COMPONENT PERSONNEL DURING INDIVIDUAL AND ANNUAL TRAINING

A Graduate Research Project

Submitted to the Faculty of

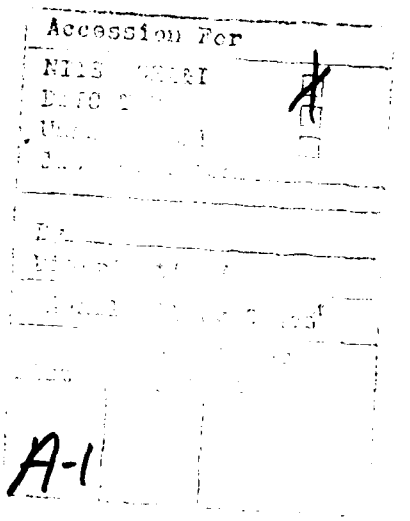
Baylor University

In Partial Fulfillment of the

Requirements for the Degree

of

Master of Health Administration




By

Major Brian P. Foley, MSC

August 1984

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I would like to express my gratitude to the following individuals who gave generously to me time from their hectic schedules in order to assist me in this study:

COL Richard E. Meiers, MSC, Chief of Staff/Preceptor, Fitzsimons Army Medical Center
LTC James L. Howell, MSC, Faculty Advisor, Academy of Health Sciences
COL Roosevelt D. Butler, MSC, Medical Readiness Coordinator, US Army Readiness and Mobilization Region VIII
LTC Dennis P. McKnight, MSC, ARNG Advisor, Academy of Health Sciences
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Ms. Teresa M. Foley, RRA, Consultant
Ms. Linda D. Walters, Admin Assistant, Chief of Staff's Office

Without their assistance this research would not have been possible.

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# I. INTRODUCTION

## Conditions Which Prompted the Study

Presently greater than seventy percent (70%) of the Army Medical Department's (AMEDD) mobilization capabilities are found in the Reserve Components (RC), consisting of the United States Army Reserve (USAR) and Army National Guard (ARNG). Under the "One Army Concept" and austere budgets, the role of the RC in both mobilization and peace time support activities has become more critical. The importance of the RC can be seen in the increased authorization of active component (AC) personnel to support the RC and the increased level of resources being dedicated to the modernization of RC units.

In this austere environment, the RC and AC are more mutually dependent upon each other than at any other time in the history of the AMEDD. Besides depending on the RC for mobilization, the active components must rely upon them to augment their staffs in providing patient support in almost all of the Army medical centers, community hospitals, health clinics, dental clinics, troop medical clinics, and veterinary activities. In many instances, without the RC personnel, the accomplishment of many missions would be more difficult. The RC need the assistance of AC medical treatment facilities (MTF) in providing the necessary environment for training personnel. From my experience in a Readiness Group, I know this training is critical because the majority of RC service members do not work in civilian occupations related to their Military Occupational Specialty (MOS).

Even though the AC and RC compliment each other, neither one is

working to its full potential in many instances. I have observed that AC MTF are not fully making use of the potential of RC resources in providing patient care, increasing services (such as operating clinics at night and on weekends), and reducing AC staffing requirements. The reasons for this are many: (1) Credentialing of RC personnel. (2) Not trusting RC personnel with equipment. (3) RC personnel not being MOS qualified. (4) Lack of coordination between RC and AC. (5) Failure to appoint patients for RC health providers. (6) Lack of initiative in part by both the RC and AC in developing programs. (7) Not assigning responsibilities and (8) Rapid changeover of personnel. Because the RC personnel are not being used to their full potential, they are not receiving the training necessary for them to perform their mission responsibilities upon mobilization. It is common to find RC personnel in an AC MTF during Individual Training (IDT) and Annual Training (AT) not being assigned specific duties and responsibilities or adequately supervised. Another common problem is that the RC personnel perform only mundane, tedious and repetitious tasks month after month.

The preceeding remarks do not mean that there are not many good mutually beneficial relationships between RC units and AC MTF. But, presently the methods and innovative approaches of the successful MTF are not being consolidated or communicated. Each MTF's AC and RC programs operate in a vacuum from other MTF's programs. The purpose of this research is to find proven and/or innovative approaches for improving the ability of:

1. RC personnel to augment and expand the capabilities of AC MTF

in the performance of all facets of mission responsibilities.

2. AC MTF to provide opportunities for individual and collective training to RC personnel for the performance of their mobilization mission.

The existence of a significant problem in the training and utilization of RC personnel in AC MTF is verified by Colonel Roosevelt D. Butler, MSC, RA, Medical Readiness Coordinator, US Army Mobilization and Readiness Region II and LTC Dennis P. McKnight, MSC, ARNG, Advisor to the Commandant of the Academy of Health Sciences. Their letters to verify the existence of this problem are included as Appendixes B and C respectively.

The HSC Commander's Notes of November 1983 states: "It is rare indeed to find a MEDCEN or MEDDAC that has not had an acute personnel shortage in which the Reserve Components have not come to their rescue".[1] This statement also supports the need for AC MTF to find optimal methods to properly utilize RC personnel in the accomplishment of assigned missions.

## Statement of Research Question

How can Reserve Component assets be better utilized in order to optimize the mission capabilities of Active Component Army Medical Department Treatment Facilities and at the same time optimize the individual and collective training received by Reserve Component personnel during Individual Training and Annual Training?

## Objectives

1. Validate the need for the study.
2. Develop research question.
3. Develop first questionnaire and cover letter.

4. Determine respondent panel.

5. Obtain names and addresses of personnel to be utilized as respondents.

6. Have first questionnaire and cover letter typed and printed.

7. Address and mail first questionnaire and cover letter.

8. Analyze first questionnaire:

a. Summarize recommendations and comments by category (IDT Training, IDT Utilization, AT Training, AT Utilization).

b. Merge IDT training and IDT utilization recommendations into recommendations which combine optimum RC utilization and training.

c. Merge AT training and AT utilization recommendations into recommendations which combine optimum RC utilization and training.

9. Develop second questionnaire and cover letter.

a. The second questionnaire is to consist of:

(1) One section with IDT recommendations which combine optimum RC utilization and training.

(2) One section with AT recommendations which combine optimum RC utilization and training.

b. Each recommendation is to have a Likert scale to measure the respondents' attitudes towards the ability of the recommendation to optimize utilization and training.

10. Have second questionnaire and cover letter typed and printed.

11. Mail second questionnaire to respondents who answered the first questionnaire.

12. Analyze second questionnaire:

a. Rank order the ability of the recommendations to improve the utilization and training of RC personnel in accordance with the scores given by the respondents.

b. Determine if there is a difference in perception between the RC and AC respondents on which recommendations will improve RC utilization and training by comparing the scores of each recommendation between RC and AC respondents.

13. Write final report:

a. Data from analysis of Likert scores.

b. Narrative analysis.

c. Recommendations for future study.

14. Disseminate results for consideration by:

a. Health Services Command.

b. Respondents.

c. CONUS Army Surgeons.

d. FORSCOM Surgeon's Office.

## Criteria

1. Questionnaires were only sent to RC and AC personnel who are familiar with the training and utilization of RC personnel. See Research Methodology for detailed list of respondent panel meeting this criteria. For the purpose of this study, personnel filling these duty positions were considered "experts".

2. The final report must have as a minimum input from the following personnel:

a. Active Component.

(1) Two ARMR medical coordinators.

(2) Three Readiness Group medical team representatives.

(3) Three dedicated RC unit advisors and/or augmentees.

(4) Two AC MTF Department of Nursing representatives.

(5) Two AC MTF Plans, Operations and Training representatives.

(6) An AC MTF Executive Officer.

(7) An AC MTF Professional Services representative.

(8) An AC MTF Logistics representative.

(9) An AC MTF Patient Administration representative.

(10) Two AC MTF Command Sergeants Major.

(11) An AC HSC HQ representative.

(12) An AC OTSG representative.

b. Reserve Component:

(1) An RC advisor to AHS.

(2) An RC advisor to HSC.

(3) An individual mobilization augmentee (IMA) (MOBDES) to HSC.

(4) Three IMA (MOBDES) to AC MTF and HQ.

(5) Four RC Commanders.

(6) Two RC Executive Officers.

(7) Three RC Department of Nursing representatives.

(8) Four RC Plans, Operations and Training representatives.

(9) An RC Command Sergeant Major.

3. A minimum of twenty AC and twenty RC personnel must complete the entire process to validate the recommendations.[2] (There is no set criteria for determining this number.)

4. The final report will list all recommendations by the respondents for the optimal use of IDT and AT RC training and utilization. The applicability and benefit of these recommendations in AC MTF will be directly correlated to:

a. Likert scale measurement of the attitude of the respondent panel to the ability of the recommendation to optimize RC training and utilization.

b. Acceptability to both RC and AC personnel as measured by the differences in Likert scale scores of the RC and AC personnel.

5. The final report will include a narrative analysis of:

(a) Recommendations.

(b) Likert scale scores.

(c) Present Army training doctrine.

(d) Impact.

(e) Recommendations for further research.

## Assumptions

1. The basic mission of the RC and AC will not change.

2. Recommendations will not be specific to an institution.

3. AC and RC personnel strengths will remain stable.

4. AC MTF will be willing for RC personnel to assume greater responsibility in mission accomplishment.

5. RC personnel will be willing to assume greater responsibility in the accomplishment of AC MTF mission.

6. AC MTF will desire to enhance RC individual and collective training in order to enhance mobilization and peace time mission capabilities.

7. There will be no material increase or decrease in funding to affect the utilization and training of RC personnel in AC MTF.

8. A sufficient number of the panel of respondents will participate in this research to meet the criteria outlined.

## Limitations

1. This study will be limited to the utilization and training of RC personnel in U.S. Army Health Services Command (HSC) MTF.

2. The level of MOS qualification of RC service members will directly impact on the services they can provide the MTF.

3. Many RC units will have a low Medical Corps strength.

4. RC personnel will be available only 39 days a year.

5. This study will not address AMEDD RC training outside of AC MTF.

6. The quality of the recommendation for the optimal utilization and training of RC personnel in AC MTF will be only as good as the input provided by the panel of respondents.

## Research Methodology

1. Using the modified Delphi Technique[3], recommendations were generated from key personnel in the Reserve Components and from Active Component personnel who interact with RC personnel as part of their assigned duties. Since this study involves various reference groups, a large respondent panel was required.[4] The following respondent panel was used to provide a wide spectrum of viewpoints:

a. Active Component respondent panel was composed of a sample of the following personnel:

(1) The CONUS Army Surgeons (First, Fifth, etc.).

(2) ARMR Medical Coordinators.

(3) Readiness Group Medical Team representatives.

(4) Dedicated advisors/augmentees to RC units.

(5) HSC representatives.

(6) OTSG representatives.

b. In each MEDCEN and MEDDAC, a sample of the following individuals was asked to participate, thus gaining a random representative sample of the recommendations of the different duty positions (i.e., in one MTF, it was the Chief, Plans, Operations and Training; and in another, it was the Chief Nurse, etc.).

(1) Commanders.

(2) Executive Officers/Chief of Staffs.

(3) Professional Services/Deputy Commander representatives.

(4) Department of Nursing representatives.

(5) Plans, Operations and Training representatives.

(6) Logistics representatives.

(7) Personnel representatives.

(8) Comptroller representatives.

(9) Patient Administration Division representatives.

(10) Command Sergeants Major.

2. The Reserve Component respondent panel:

a. Each of the following personnel was asked to participate:

(1) General Officer, MOBDES to HSC

(2) USAR Advisor to Commander, HSC

(3) ARNG Advisor to Commander, HSC

(4) USAR Advisor to Commandant, AHS

(5) ARNG Advisor to Commandant, AHS

b. A sample of the following RC personnel was asked to participate (in one unit it was the Commander, and in another it was the Chief Nurse, etc.).

(1) Commanders.

(2) Executive Officers.

(3) Professional Services representatives.

(4) Department of Nursing representatives.

(5) Plans, Operations and Training representatives.

(6) Logistics representatives.

(7) Personnel representatives.

(8) Comptroller representatives.

(9) Patient Administration Division representatives.

(10) Command Sergeants Major.

3. Recommendations from respondents who did not complete the entire Delphi Technique process were not utilized.

4. Criteria: See Criteria Section.

5. Even though the issues of utilization and training of RC personnel in AC MTF are mutually dependent upon each other, they were addressed separately in the first Delphi questionnaire. It is realized that training should be part of the utilization, but in order to focus respondents upon each of the issues, they were addressed separately. These issues were tied together in the second questionnaire.

Questionnaire #1 (Appendix D):

The first questionnaire was a letter to a representative sample of personnel in the above listed duty positions inviting them to participate in the study. RC and AC personnel received the same identical letter. The questions were open-ended in order to generate a variety of responses. Personnel who did not respond to this letter did not receive the second questionnaire. Two-hundred and twelve (212) first questionnaires (100 AC, 112 RC) were mailed out in order to take into account nonparticipants and dropouts from the process. The number of AC and RC personnel included in the process was weighted to assure equal representation. It was desired for the purpose of this study to have a minimum of forty participants (20 from AC and 20 from RC) finish the process.

Questionnaire #2 (Appendix E):

The respondents to the first questionnaire provided recommendations in four areas:

RC IDT Training

RC IDT Utilization

RC AT Training

RC AT Utilization

As stated above, the questionnaire was designed in this manner to force respondents to focus on each of these issues. The purpose of this study is to discover methods to optimize both RC training and utilization in AC MTF. This is best accomplished by finding activities which will simultaneously provide training to the RC personnel and utilization for the AC MTF. In order to accomplish this, the recommendations for IDT training and IDT utilization were merged by the researcher into recommendations for activities which RC personnel can perform in an AC MTF which provided both optimal training and utilization simultaneously. The respondents' recommendations for AT training and AT utilization were also merged into single recommendations which combined optimum training and utilization.

This process of merging the separate recommendations for training and utilization and combining them into recommendations which optimize both was one of the most important and time consuming parts of the study.

After this process was completed, the respondents (33 AC, 37 RC) who answered the first questionnaire were sent a second questionnaire which consisted of two sets of recommendations:

1. IDT recommendations for simultaneously training and utilizing RC personnel.

2. AT recommendations for simultaneously training and utilizing RC personnel.

Each recommendation had under it a Likert scale[5] for the respondents to express their attitude towards the benefit of the recommendation for the optimal training and utilization of RC personnel:

| SA | A | U | D | SD |
|---|---|---|---|---|

SA = Strongly Agree = Value of 1

A = Agree = Value of 2

U = Undecided = Value of 3

D = Disagree = Value of 4

SD = Strongly Disagree = Value of 5

Under each scale, there was also space for respondents to comment on the recommendation.

Analysis:

The scores for each recommendation from the 29 AC and 29 RC respondents to the second questionnaire were analyzed in order to indicate the level of agreement that the respondent panel had as a whole for the ability of each recommendation to optimize the training and utilization of RC personnel in an AC MTF.

The scores given to each recommendation by the AC and RC respondents respectively were also analyzed to determine if there was a difference in perspective to the benefit of any given recommendation. The perspective of the AC respondents might be towards greater utilization and the perspective of the RC respondents might be towards greater training opportunities.

A narrative analysis was done of the: (1) Respondents' recommendations. (2) Likert scale scores. (3) Current Army training doctrine. (4) Current methods of utilization and training. (5) Impact of recommendations. (6) Areas requiring further research. This analysis was accomplished in order to tie all of these elements together into a cohesive strategy for the utilization and training of RC personnel in AC MTF.

This report was sent to HSC, the CONUS Army Surgeons and the FORSCOM Surgeon's Office for their consideration. Each respondent has also received a copy of this report.

## II. DISCUSSION

### Respondent Panel

The first questionnaire (APPENDIX D) was sent to 100 AC personnel and 112 RC personnel for a total of 212 questionnaires. The personnel to whom these questionnaires were sent were in accordance with the panel outlined in the Research Methodology section of this study.

Thirty-three (33) AC and thirty-seven (37) RC personnel, for a total of seventy (70) personnel, responded to the first questionnaire. Of this group, twenty-nine (29) AC and twenty-nine (29) RC for a total of fifty-eight (58) personnel completed the entire process of answering the two questionnaires. The list of AC personnel who completed the process is found in APPENDIX F and the list of RC personnel is found in APPENDIX G.

The personnel that completed the entire process met the criteria outlined in the CRITERIA section of this study.

The next three sections of this paper are concerned with:

1. Problems in the optimum utilization and training of RC personnel in AC MTF.

2. Methods to optimize the training of RC personnel in AC MTF.

3. Methods to optimize the utilization of RC personnel in AC MTF.

These three sections are based upon an analysis of the narrative comments from the respondents' first and second questionnaires.

### Problems in the Optimum Utilization and Training of RC Personnel in AC MTF

Many problems exist in the proper training and utilization of RC personnel who perform IDT and AT at AC MTF. The basic causes of these problems are a lack of planning, communication and coordination involving

both the RC unit and the AC MTF. Because of this, the RC do not receive the "hands on" patient care training they need nor does the AC MTF receive the assistance in executing mission responsibilities it so desperately requires in these days of dwindling resources. As the Army decreases its combat service support strength in the AC and places these resources in the RC, the AC MTF must reevaluate its utilization of RC personnel. This transfer of combat service support strength to the RC is part of the Army's plan in FY 85 to activate a light infantry division, an additional Ranger battalion, and continue converting the ten armored and mechanized infantry divisions to the "Division 86" heavy division TO&E.[6]

The beginning of today's problems in the proper utilization and training of RC personnel in AC MTF is to be found in the Vietnam era. During this period, the RC had a surplus number of personnel because of the draft. In many instances, the RC units had more personnel than they could properly command and control. The AC MTF became a convenient place to dump and park these people for IDT. There was no incentive during this period for the AC or RC to properly train or utilize these people because all of the emphasis was on the AC.

Today, versus the Vietnam era, the RC is an integral part of our national defense efforts. The RC provides nine (9) of twenty-six (26) Army divisions, sixty-eight percent (68%) of the total Army's nondivisional combat units, sixty-nine percent (69%) of the tactical support forces, half of the special theater forces and thirty-four percent (34%) of the general support forces.[7] Many RC units, to include AMEDD units, are designated as part of the Rapid Deployment Force (RDF). Thus, in recent years we have seen ever increasing special attention to manning, equipping, and

modernizing the RC. No longer can the Defense Establishment afford the luxury of RC personnel "killing time" in drill halls and "parked" in an AC MTF during IDT and AT. Our strategists predict that the next war will be a "come as you are" affair. Because of the critical early deployment missions of the RC, they will also have to "come as they are". Historically, during the post-mobilization period, months were spent in preparing the RC for combat while the AC "held the line". Today the RC must be prepared for combat at mobilization.

The respondents to this study report that the problems in training RC personnel in AC MTF during IDT and AT are:

1. The AC MTF are inundated with too many RC personnel for them to properly absorb.

2. RC personnel traditionally perform IDT on weekends when there is a low inpatient census, only emergency surgery is performed, and the outpatient clinics are closed.

3. The administrative burden of the RC units require them to frequently remove personnel from the AC MTF for a myriad of administrative requirements.

4. RC personnel are used primarily for housekeeping and "gopher" duties.

5. RC personnel perform the same tasks in the AC MTF month after month, year after year.

6. RC personnel are not trained in tasks they will require for Skill Qualification Testing (SQT) or upon mobilization.

7. In AC MTF RC personnel train as individuals and not as part of a

section or team. The AC MTF does not offer them the opportunity to perform collective training.

8. Many RC personnel do not train with the TO&E type of patient care equipment they will be expected to use upon mobilization.

9. Many RC personnel are not utilized in the AC MTF in the MOS they will be expected to fill upon mobilization. For example, OR technicians (91D) are frequently utilized on wards instead of the OR during IDT.

10. During IDT, RC personnel do not have access to equipment and supplies required for training because they are locked up for the weekend.

11. Many AC MTF do not plan for the proper utilization (which fosters training) of the RC personnel.

12. During IDT AC MTF command, supervisory and staff personnel are not available.

13. Many AC MTF personnel are not interested in the RC.

14. Many RC personnel are not allowed to function in the AC MTF in accordance with their skills and level of responsibility.

15. Many RC command, staff and training personnel do not plan, supervise or monitor the training that is performed by their personnel in the AC MTF. "Showing up" at the AC MTF is considered their "training".

16. AC personnel assigned to RC duty (Readiness Groups, Dedicated Advisors, etc.) often do not check the quality of training being performed at AC MTF. Training inspections, the vast majority of the time, are limited to training documents and what can be observed in the RC facility or in a field environment.

17. Often there is very little communication between the AC MTF and the

RC unit's command structure.

18. Often there is very little evaluation by the AC MTF personnel of the training performed by the RC personnel.

19. Many RC personnel felt they are treated as "second class" citizens by the AC MTF personnel.

20. Many first line RC supervisory personnel do not assume responsibility for monitoring or recording the training received by their personnel in the AC MTF.

21. Many AC MTF are only interested in utilizing the RC personnel and not training these personnel.

22. The administrative burden of the RC unit does not allow it to send its administrative and logistical personnel (to include medical records clerks (71G)) to the AC MTF for training.

23. Many AC AMEDD officers are not familiar with standard Army training doctrine such as BTMS (Battalion Training Management System), Soldier Manual Tasks, Job Books, ARTEP, etc.

The respondents reported the following problems during IDT and AT in the utilization of RC personnel in AC MTF:

1. RC personnel primarily perform IDT on weekends when many activities are closed and there is a low workload.

2. RC units performing AT at the AC MTF have too many RC personnel to be completely absorbed.

3. Many RC personnel are not MOS qualified or require too much supervision to be of value to the AC MTF.

4. Often the AC MTF cannot rely upon the RC personnel reporting for

duty enough to allow the AC MTF to adjust the scheduling of AC personnel.

5. Often RC MC (physicians), ANC (nurses), MSC (allied health providers), AMSC (physical therapists, and occupational therapists), and DC (dentists) officers have not been credentialed by the AC MTF and thus cannot be involved in direct patient care.

6. Often the only AC MTF personnel involved in the planning and coordination of the utilization of RC personnel during IDT and AT is the AC MTF's Plans, Operations and Training personnel.

7. The AC MTF does not have input into the evaluation of the RC personnel who train at the MTF.

8. The AC MTF is reluctant to allow RC personnel to operate clinics, operate equipment, work in medical records, etc., because on weekends there are no AC personnel present to supervise and insure property accountability.

9. RC personnel tend to be assigned to the AC MTF as individuals and there is no one "in charge" from the RC unit. This places an additional supervisory burden on the AC MTF.

10. Many RC units only have their personnel perform IDT during the day shift and not during the evening and night shifts on which they could be better utilized.

11. Often RC personnel cannot be relied upon to work a complete shift because they must leave the AC MTF activity to which they are assigned in order to go to RC unit for administrative requirements, didactic training, etc.

12. Conflict develops between AC and RC personnel over appearance, uniform, and height and weight standards.

13. Not enough prior coordination is performed between the AC MTF and the RC unit to assure RC personnel are assigned where they are most needed.

14. The AC MTF does not know the training needs of the RC personnel and thus does not utilize them where they would receive the required training.

15. The assignment of RC personnel one weekend a month for IDT to the AC MTF does not provide enough continuity for good utilization.

16. RC individual personnel are either switched too often or not present enough at an AC MTF activity to become familiar enough with its operations to be of much value.

17. The AC MTF does not know enough about the training, background and aspirations of the RC personnel to properly plan the assignment of these personnel for proper utilization.

18. RC administrative and logistical personnel are usually kept at the RC unit and are not available to the AC MTF for utilization.

19. Even in AC MTF that have an RC augmentation unit, there are two distinct chains of command with different goals and objectives. The MTF reports to HSC and the RC unit to an ARCOM (Army Reserve Command).

20. AC MTF personnel do not actively seek methods in which to utilize RC personnel in the accomplishment of the MTF's mission.

The next section of this study will suggest methods which can be used by the AC MTF and the RC units to optimize training and utilization. The aim is to develop methods which will optimize the mission capabilities of AC MTF and at the same time optimize individual and collective training received by RC personnel during IDT and AT.

## Methods to Optimize the Training of RC Personnel in AC MTF

As stated in the last section, the basic causes for poor training and utilization of RC personnel in AC MTF are lack of planning, communication and coordination by both the RC unit and the AC MTF. The first step is for the RC unit to identify exactly what training it needs to accomplish. It is important to remember that utilization of RC personnel by the AC MTF is primarily a means of providing training to the RC personnel involved. AC MTF utilization of RC personnel is not an end in itself but is a vehicle for the RC unit to fulfill its training responsibilities. The utilization the AC MTF receives from the RC personnel is a by-product of this training process.

The first step in optimizing utilization and training in the AC MTF is for the RC unit to specifically identify what training its personnel requires. Many RC units do not apply to the training performed in AC MTF, standard Army training doctrine. In many instances, the only planning involved for the RC personnel who perform IDT or AT at an AC MTF is for them to report to a given ward, clinic or section.

The RC unit can identify what are its training requirements by following the procedures outlined in standard Army Regulations, directives and Field Manuals:[8]

1. The RC unit should identify specifically what tasks individually and collectively it must perform in order to accomplish its mobilization mission. This analysis should include: (See Figure 1)

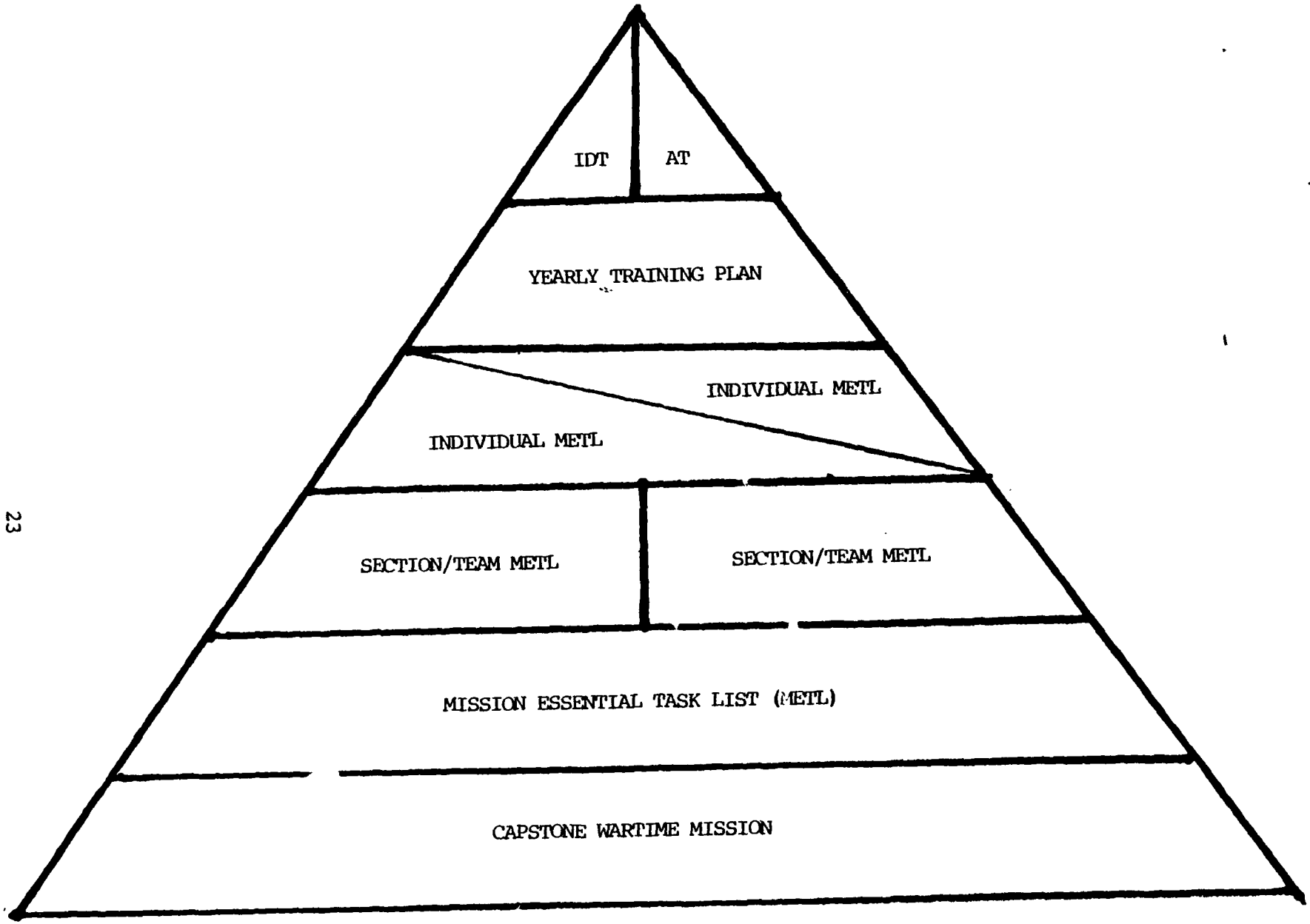


Figure 1.

The Pyramid of Training Management

a. Post mobilization plans and missions. This is possible through coordination with the RC unit's CAPSTONE (unit's chain of command upon mobilization) higher headquarters.

b. Identification of collective tasks from the unit's ARTEP (Army Training and Evaluation Program) which supports the unit's mobilization mission. FORSCOM Regulation 350-2 (RC Training dated 1 October 1983) requires RC commanders to develop a Mission Essential Task List (METL). This must include the identification of specific ARTEP collective tasks for sections/teams. (Units which do not have an ARTEP should develop their own standards.)

c. Identification of Soldier Manual (SM) tasks and any individual tasks (critical to mission accomplishment but not included in an SM) which are required to support mobilization collective task requirements. It should be noted that every position in the unit with the same Military Occupational Skill may not be required to perform all the same tasks (i.e., a 91B ward attendant and a 91B ambulance driver do not perform all of the same tasks).

d. Identification of training required for individuals who are not MOS qualified. After initial qualification in the individual's, MOS then emphasis should be placed on the training the individual will require to support the unit's mobilization mission.

e. Identification of the unit's mobilization configuration. The unit should develop and maintain an organization chart (wire diagram) for their unit in accordance with its mobilization mission. The unit should organize itself in accordance with its wartime configuration for training.

The unit should attempt to maintain mobilization section integrity in all training situations. If complete section integrity cannot be maintained, then integrity to the lowest level possible should be attempted. The first line supervisor must be held responsible for training, developing and motivating the individuals in his/her group.

f. A thorough listing of all individual and collective tasks required for mobilization. This list should result from the analysis described above. The format may consist of annotated copies of ARTEP consolidated task inventories, extracts of commander's manuals (Trainer's Guides), card listings, etc.

2. After this analysis, the unit should determine its present status of training. This can be accomplished by determining in which individual and collective tasks the unit is proficient. The individual and collective tasks which the unit is not proficient in should be prioritized. This prioritized list of training shortfalls should be the basis of the unit's individual and collective training programs. This prioritized list should be kept up-to-date as training is completed and updated when necessary.

3. The unit should then plan when and where the tasks identified for training will be accomplished. Tasks should be identified for training during the current training year, the following training year or after mobilization. Training identified for the current training year should be identified for accomplishment either during IDT or AT. This is the basis of the unit's Yearly Training Plan (YTP).

4. Next, the unit needs to identify the resources needed to accomplish the training on its YTP. Resources include the weapons qualification

ranges, ammunition, AC MTF field training sites, etc. It is important to note here the AC MTF is a resource for training and is not a panacea for all of the unit's training requirements or an end in itself. Many collective and individual tasks cannot be trained in an AC MTF.

Only after the RC unit has specifically identified the training it needs to accomplish in an AC MTF should it begin negotiating with the AC MTF. In planning IDT training with an AC MTF, the RC unit should:

1. Insure that it does not inundate the AC MTF with more RC personnel than it can absorb at any one time. When possible, utilize more than one weekend a month, second and third shifts and week nights for training.

2. Try to schedule RC personnel as much as possible in accordance with section/team integrity. For example, if the AC MTF cannot absorb an entire RC ward team on one of its wards at the same time, then have the RC ward team spread over several AC MTF at the same time but still have that RC ward team's Head Nurse and Chief Wardmaster be accountable for their personnel.

3. Identify specific tasks to be trained during each IDT period. Hold RC chain of command responsible for the training and documentation of tasks.

4. Insure that the professional officers (MC, ANC, AMSC, DC, MSC) of the RC unit are an integral part of the unit's training program of the enlisted service members. The RC professional cadre should be given specific responsibilities in training RC enlisted personnel while in the "hands on" environment of the AC MTF.

5. Minimize pulling RC personnel from the "hands on" environment of

the ward or clinic for administrative matters, didactic training or common soldier skill training. The RC unit should use a system of cyclic rotations for teams and sections. The team/section could be scheduled for x number of IDT periods of "hands on" training at the AC MTF followed by x number of IDT periods of common soldier skill training and x number of IDT periods of administrative processing. Ideally, there would be several different team/section cycles being performed simultaneously. For example, one RC ward would be in their hands on training at the AC MTF while another RC ward is performing common soldier skill training and another one is receiving didactic training.

6. Develop a written Memorandum of Understanding (MOU) with the AC MTF specifically delineating the responsibilities of each party. This MOU should be widely disseminated in the RC unit and AC MTF.

7. Meet quarterly with the AC MTF to evaluate the progress of the IDT training program. Besides representatives from the AC MTF and RC unit's Plans, Operations and Training sections, representatives from nursing should be present at these quarterly meetings.

8. Have its command element frequently visit the AC MTF during IDT to access the validity of training being performed.

9. Accomplish AC MTF credentialing requirements for RC personnel prior to the commencement of IDT.

10. Coordinate with the AC MTF for the assignment of mission responsibilities in accordance with training requirements. The responsibility of operating a clinic or ward utilizing the RC unit's organic chain of command during IDT is a good example. The AC MTF could be requested to schedule

patients in support of this operations.

11. Insure that the training of RC low density MOS is not ignored. For example, often patient administration specialists (71G) are utilized by the RC unit as additional clerk-typists and never given the opportunity to function in their MOS.

12. Train with organic TOE medical equipment whenever possible.

In planning AT training (in accordance with unit's YTP) with an AC MTF, the RC unit should:

1. Insure that it does not inundate the AC MTF with more personnel than it can absorb at any one time. If RC personnel are to be scheduled for AT in more than one increment, try to maintain section/team integrity as much as possible per increment (i.e., schedule one RC ward team for one increment and another RC ward team for another increment—maintain organic chain of command). Avoid scheduling RC personnel as individuals to AT. When the entire unit performs AT in one increment and the size of the RC unit does not allow it to be properly absorbed by the AC MTF, the RC unit should plan alternative training. This can be accomplished by rotating sections/teams through the AC MTF during the AT period. For example, one RC ward team receives common soldier skill training and didactic training while another RC wardteam receives "hands on" training in the hospital. After x number of days, the two RC ward teams switch places.

2. Insure that the pre-camp conference addresses more than "housekeeping" functions. Issues such as credentials, detail assignments of personnel, individual and collective tasks, duty hours, specific responsibilities, etc., need to be discussed. RC and AC Nursing Department

representatives should be present during the pre-camp conference. The pre-camp conference should produce a written document addressing specific details of how the training objectives that are agreed upon will be accomplished. This document should be widely disseminated in the RC unit and AC MTF.

3. Concentrate on collective task training and only individual task training which cannot be accomplished during IDT. For example, "hands on" operating room experience is often not available during IDT.

4. Identify with the AC MTF missions, such as operating a ward, pharmacy, laboratory, dispensary, etc., which RC personnel may perform utilizing the RC unit's organic teams/sections and chain of command.

5. Meet daily during AT with the AC MTF staff to assess training accomplishment and the performance of the RC unit. This would allow for the correction of problem areas as they occur and circumvent any discord that could result from poor communication.

6. If it is a RC TO&E Corps level medical unit, concentrate on operating in a field environment for the majority of its AT. When conducting AT at an AC MTF, a TO&E Corps level medical unit's objective should be the collective training of sections/teams in a "hands on" patient care environment. For example, usually during IDT an RC unit does not have the opportunity to have an OR team conduct surgery. AT at an AC MTF gives the RC unit the opportunity to exercise its OR team(s) in actual surgery.

7. If it is a RC TO&E Corps level medical unit, affiliate with a AC like TO&E Corps level medical unit for AT. When the RC unit is conducting AT in a field environment, affiliation with a like AC TO&E unit will give

it access to TO&E equipment—expertise that is probably not available to the RC unit during IDT. When the RC TO&E Corps level medical unit is conducting AT at an AC MTF, affiliation with a like AC TO&E unit to utilize some organic TO&E equipment in a patient care hands on environment.

Methods to Optimize the Utilization of RC Personnel in AC MTF

In the planning for the utilization of RC personnel, the AC MTF must keep in mind that the primary purpose of RC utilization is hands on training. Proper utilization by the AC MTF is the best method of providing RC personnel with patient care training. Also, proper utilization of RC personnel while assisting the RC personnel with training can also assist the AC MTF to accomplish its mission responsibilities. In order for the AC MTF to optimize RC utilization while at the same time providing optimal training during IDT and AT, it should:

1. Insure excellent communication and planning with the RC unit that is going to perform IDT or AT at its facility. The AC MTF must know what training the RC unit desires at its facility and the RC unit must know what opportunities exist at the AC MTF. This can be accomplished by frequent meetings between the AC MTF and RC unit to discuss training and utilization issues affecting IDT. These meetings must not only include Plans, Operations and Training personnel but also must include representatives from the major functionary area such as the Department of Nursing. A successful AT is dependent upon a good pre-camp conference. The pre-camp conference must address more than "housekeeping". It must address specific issues such as credentialing, specific individual and collective training tasks, personnel scheduling and evaluation criteria.

2. Develop a written document for IDT and/or AT which specifically delineates the responsibilities of the RC unit and the AC MTF. This document should be widely disseminated in the RC unit and AC MTF.

3. Identify and coordinate with the RC unit assistance in correcting staffing and mission shortfalls which coincide with the RC unit's training objectives. This requires detailed planning by both the AC MTF and RC unit.

4. Whenever possible, identify missions which the RC unit can accomplish utilizing its organic sections/teams.

5. Whenever the RC unit is given a mission, such as operating a clinic or conducting physical exams, the unit should not be booked solid. The unit should have enough time to train its personnel as the mission is being accomplished.

6. Conduct periodic joint assessments during IDT with the RC unit to evaluate the effectiveness of training and utilization. This would allow for the correction of problem areas as they occur and circumvent any discord that could result from poor communication. During AT, this joint assessment should be done daily.

7. Take its responsibility to evaluate RC units during AT very seriously. The AC MTF should provide the RC unit with an honest objective evaluation to include specific methods to improve weaknesses. An AC MEDCEN should dedicate an officer to full-time evaluation when a battalion size or greater RC unit performs AT at its facility during one increment.

8. Train RC personnel who utilize the AC MTF in Hospital and Fire Safety, Infection Control, "CODES", medical record documentation,

incident reporting procedures, etc. This should be done periodically during the year for RC personnel performing IDT at the facility. The AC MTF should provide RC personnel who are performing AT at the facility an indepth orientation to include these subjects at the beginning of AT.

9. Establish a sponsorship program for RC personnel who perform IDT and AT at the facility. The sponsorship program can consist of individual or group sponsorships (i.e., an AC wardmaster sponsors an RC wardmaster, the AC lab sponsors the RC lab, etc.)

10. Determine if the AC MTF mobilization plans for the utilization of augmentation units, IMA's, etc., meet the mobilization needs of the facility. The AC MTF should utilize RC personnel during IDT and AT in much the same manner as is required upon mobilization.

11. Remember to treat RC units in accordance with the "One Army" concept.

12. Use initiative, communication and detailed coordination in planning the training and the utilization of RC personnel. Involve all levels of the AC MTF and RC unit in the process.

## III. RECOMMENDATIONS

### Respondents' IDT Recommendations

The following are the recommendations (APPENDIX E) to optimize the training and utilization of RC personnel during IDT at AC MTF in descending order of agreement (the higher the mean score, the more negative the response of the respondent panel):

1. RC personnel performing IDT at AC MTF should be required to meet AC appearance, weight and physical fitness requirements. (Mean 1.36)

2. The RC unit must provide the AC MTF with a clear statement of the RC unit's mobilization mission, training requirements and capabilities. (Mean 1.57)

3. Allow RC personnel in supervisory grades/positions to do the work that is commensurate with their grade/position. Give them the responsibility and authority to get a job and mission done. (Mean 1.59)

4. AC MTF personnel should maintain close contact/dialogue with the RC unit whose personnel do training at the AC MTF. AC MTF personnel should, on occasion, visit the RC unit to gain firsthand knowledge of the RC unit's staff and to brief the staff on the progress of RC personnel performing IDT at the AC MTF. AC MTF supervisors and staff should be available in their duty sections on occasion during IDT to reinforce the "One Army Concept". (Mean 1.62)

5. RC personnel should be required to have their "Job Book" during IDT at an AC MTF. (Mean 1.76)

6. RC units must insure that they do not inundate the AC MTF with more personnel than can be given hands-on experience. (Mean 1.77)

7. There should be scheduled quarterly meetings between AC MTF personnel (PO&T, Department of Nursing, etc.) and the RC unit(s) performing IDT at the MTF. A continuous dialogue will assist the communication process. (Mean 1.79)

8. The AC MTF should make available to the RC unit classroom space and audio-visual equipment. (Mean 1.79)

9. RC personnel should be fully integrated with AC personnel in the AC MTF. The RC personnel should be allowed to do the same tasks as their AC counterparts. (Mean 1.81)

10. AC MTF personnel should be utilized to train RC trainees--"train the trainer". (Mean 1.84)

11. The AC MTF should give the RC unit (within its capabilities) missions to accomplish, such as totally operate a clinic, ward, pharmacy or physical exam service, perform inventories, write plans, etc. (Mean 1.86)

12. The AC MTF and the RC unit(s) performing IDT at the MTF should have a written memorandum of agreement (MOA) specifically outlining the responsibilities of the AC and RC. (Mean 1.88)

13. Careful coordination is required between the AC MTF and the RC unit to insure that the MTF does not have an excess of staff on duty. (Mean 1.91)

14. RC utilization and training in AC MTF should be geared toward the RC unit's mobilization mission. (Mean 1.91)

15. RC personnel should always be trained at the AC MTF and not just used as bodies. (Mean 1.93)

16. The AC MTF should establish a sponsorship program for RC personnel

who perform IDT at the MTF (i.e., an AC wardmaster sponsor an RC wardmaster, etc.). (Mean 1.95)

17. RC personnel should be rotated among various jobs. RC personnel should not perform the same job (i.e., physical exam, ER, ward) year after year. (Mean 1.95)

18. The AC MTF and RC unit must conduct detailed planning before the commencement of IDT training at the facility. (Mean 1.96)

19. The AC MTF should have input into the efficiency ratings of RC personnel who regularly perform IDT at the facility. (Mean 1.98)

20. All training at AC MTF should be geared towards the RC unit's mobilization mission. (Mean 1.98)

21. If the RC unit is given a mission such as operating a clinic or conducting physical exams, the unit should not be booked solid. The unit should have enough time to train its personnel as the mission is being accomplished. (Mean 2.00)

22. Medical record documentation is a major problem for RC personnel. RC units should hold specific classes on this subject in the unit prior to IDT assignment. (Mean 2.02)

23. The AC MTF must assume a responsibility in the evaluation of RC training performed at its facility. (Mean 2.02)

24. Allow qualified RC personnel to assume OIC and NCOIC positions to include supervision of AC personnel. (Mean 2.03)

25. RC personnel would receive better training and the AC MTF greater utilization if IDT were not limited to weekends. Greater effort should be made between the RC units and the AC MTF to allow RC personnel to perform IDT during normal duty hours and on week nights. (Mean 2.03)

26. BIMS principles are extremely important in the training and utilization of RC personnel in AC MTF. (Mean 2.12)

27. If the AC MTF can't provide training in required tasks, the AC MTF should not be utilized for IDT. (Mean 2.22)

28. RC personnel should be assigned different soldier manual tasks for teaching and testing each IDT period. (Mean 2.27)

29. The RC needs to be more selective in the utilization of AC MTF for IDT. (Mean 2.27)

30. All RC personnel who utilize an AC facility for IDT should be formally trained by the AC MTF in Hospital and Fire Safety, Infection Control, IV Therapy, CPR, medical record documentation, etc. (Mean 2.28)

31. When more than one RC person performs simultaneous IDT, one should be designated as "in charge" and should be responsible for the training of the other. (Mean 2.28)

32. RC personnel should be given the mission of training AC personnel (EFMB, NCODP, SQT, in-service nursing education, CME, etc.). (Mean 2.29)

33. RC units should utilize organic equipment during IDT at AC MTF as much as possible. For example, utilize tests and organic x-ray, laboratory equipment to perform physical examinations, dental procedures, etc. (Mean 2.36)

34. Only allow RC personnel that can actually benefit from the training at an AC MTF to perform IDT at an AC MTF. (Mean 2.36)

35. AC personnel do not display enough interest in RC affairs. (Mean 2.37)

36. Each AC MTF should have its own RC augmentation unit. The TDA of this RC augmentation unit would specifically match the positions in the AC

MTF which will require "back filling" upon mobilization. (Mean 2.38)

37. RC personnel should be utilized during IDT to provide services to eligible beneficiaries that are not normally available, such as dental care to dependents. (Mean 2.39)

38. RC personnel should be required to remain for a full shift when assigned to a nursing unit and not pulled out for administrative matters or training at the RC unit. (Mean 2.40)

39. Stabilize RC personnel so that they work in the same position for at least one year. (Mean 2.41)

40. An RC unit should not schedule all of its personnel at the AC MTF for one weekend a month. Each weekend of the month should be utilized in order to provide better training to RC personnel and better utilization by the AC MTF. (Mean 2.42)

41. RC personnel performing IDT in an AC MTF should not be utilized as individuals but instead as part of a section or team of the RC unit (i.e., utilize RC personnel in accordance with RC chain of command). (Mean 2.46)

42. AC MTF personnel should participate as trainers in the FTX exercises of the RC unit(s) who perform IDT at the facility. (Mean 2.50)

43. The basis of all RC utilization and training at an AC MTF is the RC unit's Yearly Training Plan (YTP). (Mean 2.50)

44. RC personnel should perform IDT not only during the day shift but also during the evening and night shifts. (Mean 2.50)

45. An hour each day during IDT should be established for in-service training, utilizing the AC MTF audio-visual equipment and video tape library. (Mean 2.51)

46. RC physicians should be credentialed and integrated into the AC medical staff. These RC physicians could receive IDT credit for consulting, diagnostic procedures, and patient treatment. These RC physicians would integrate their responsibilities at the AC MTF into their private practice in the same manner as they do in civilian hospitals. (Mean 2.51)

47. RC personnel should only function, in the AC MTF, in the MOS which they are assigned against the RC unit's TO&E. During IDT, they should not be utilized based on civilian acquired expertise if it is not their duty upon mobilization. (Mean 2.61)

48. RC blood bank personnel should provide blood collecting services on weekends and week nights in order to provide a source of after hour blood collecting. (Mean 2.61)

49. The AC MTF should schedule patients specifically for treatment by RC personnel during IDT periods. (Mean 2.64)

50. During weekend IDT, RC units should be responsible for 24-hour operations. (Mean 2.67)

51. RC personnel should be utilized for "batch processing" at night or weekends for the processing of laboratory samples, x-rays, computer data processing, filing of medical records, etc. (Mean 2.73)

52. RC personnel should be assigned to a specific clinical area on a regular basis for at least six months. During this IDT period the individual should not be called back to the unit. (Mean 2.74)

53. RC personnel should be integrated into the AC MTF duty rosters for AOD, MOD, Chaplain-on-call, social worker on-call, etc. Individuals pulling these duties would receive credit for IDT. (Mean 2.75)

54. AC MTF should allow access for RC personnel to equipment and supplies (x-ray, dental lab) not normally operational during IDT periods. (Mean 2.78)

55. Instead of on weekends, IDT should be performed on successive week night evenings in order for RC personnel to assure the responsibility and continuity necessary to perform duties in a clinic, ward, OR, etc. (Mean 2.81)

56. RC personnel should be utilized to relieve AC personnel from non-duty hour ER duty. (Mean 2.86)

57. RC enlisted personnel such as 91D, 91E, 91G, 91H, 91P, 91Q, 91X and 35G could be integrated into the AC MTF on-call roster and receive IDT credit for this duty. (Mean 2.88)

58. The utilization and training of RC personnel in AC MTF should include duties normally performed by DACs, such as: medical record abstracting and coding, Treasurer's Office, etc. (Mean 2.93)

59. The AC MTF should credential RC physicians (MC), nurses (ANC) and enlisted technicians (91D) to perform surgery and elective surgery should be scheduled for them on week nights and weekends. (Mean 2.98)

60. Only allow RC personnel who are formally school trained to perform IDT at AC MTF. (Mean 3.02)

61. RC personnel should be utilized to perform preventive maintenance and repair of AC MTF equipment during non-duty hours. (Mean 3.09)

62. RC personnel should be utilized for weekday early morning duties such as blood collecting, vital signs, etc. This would allow some RC personnel to perform IDT prior to commencement of their civilian job. (Mean 3.14)

63. The AC MTF should utilize RC personnel only for tasks which can be found in an appropriate soldier's manual. (Mean 3.15)

64. RC professional personnel should not be utilized for patient care in AC MTF but instead be free to directly supervise and provide "hands-on training" to RC enlisted personnel who are directly involved in patient care. (Mean 3.22)

65. RC personnel should not participate in didactic training while performing IDT at an AC MTF. (Mean 3.28)

66. RC personnel should be at an AC MTF only for training and not for utilization purposes. (Mean 3.53)

## Analysis of IDT Recommendations

The rank ordering of the respondents' IDT recommendations in the previous section represents the group consensus of the AC and RC respondents. The higher the rank of the recommendation, the more positive the respondents feel towards its ability to optimize the training and utilization of RC personnel during IDT at an AC MTF. The lower the rank of the recommendation, the less positive the respondents feel towards the recommendation's ability to optimize the training and utilization of RC personnel.

The analysis of the Likert scale scores from the IDT second questionnaire (APPENDIX E) strongly supports the main hypothesis of this study. The question with the highest negative response, number 66 (mean of 3.53) was:

" RC personnel should be at an AC MTF only for training and not for utilization purposes."

This shows that both the RC respondents and the AC respondents believe

that meaningful utilization in an AC MTF is good training and good training is good utilization. These two activities are complementary and not mutually exclusive as has been argued by some. The important aspect is that the utilization must be meaningful and well planned. The greatest difference in perceptions between the AC and RC respondents was found in the Likert scale ratings of the following recommendations:

RECOMMENDATION:

"The AC MTF should credential RC physicians (MC), nurses (ANC) and enlisted technicians (91D) to perform surgery and elective surgery should be scheduled for them on week nights and weekends."

DISCUSSION:

Fifty-eight point one percent (58.1%) of the RC respondents Strongly Agree or Agree with this recommendation compared with 40.7% of the AC respondents. This is a 17.4 percentage points difference between the RC and AC respondents. This difference in agreement is not based on the concept of credentialing RC personnel but is based on the concept of elective surgery being scheduled on week nights and weekends. The narrative comments to this question by the AC respondents reflect a concern that the logistics of scheduling elective surgery during traditional non-duty hours for the RC is just too great an undertaking that negates any positive benefit to training or utilization.

RECOMMENDATION:

"RC personnel should be at an AC MTF only for training and not for utilization purposes."

DISCUSSION:

Eighteen point five percent (18.5%) of the AC personnel Strongly Agree

or Agree with this recommendation compared with 30% of the RC personnel. This 11.5 percentage points difference is easily understood since the vested interests of the AC would be towards greater utilization of RC personnel and the RC respondents' bias would be towards training. But what is most significant is that 74% of the AC respondents and 66.7% of the RC respondents Disagree or Strongly Disagree with this recommendation which is the highest level of disagreement for any recommendation. The narrative comments to this question support the belief that both training and utilization should be optimized to the greatest extent possible. The respondents believe that good utilization is good training.

RECOMMENDATION:

"RC personnel should be integrated into the AC MTF duty rosters for AOD, MOD, Chaplain-on-call, social worker on-call, etc. Individuals pulling these duties would receive credit for IDT."

DISCUSSION:

"Forty-six point one percent (46.1%) of the AC respondents Strongly Agree or Agree with this question compared with 64.5% of the RC respondents for an 18.4 percentage points difference. This difference impacts on the "One Army Concept". While the AC personnel are reluctant to trust them with these responsibilities, the RC want to be fully integrated into the activities of the AC MTF.

RECOMMENDATION:

"AC MTF should allow access for RC personnel to equipment and supplies (x-ray, dental lab) not normally operational during IDT."

DISCUSSION:

Fifty percent (50%) of the AC respondents Disagree or Strongly

Disagree with the recommendation compared with 27.6% of the RC respondents (none of the RC respondents Strongly Disagree with this recommendation). This is the largest percentage points difference (22.4%) in perception between the RC and AC respondents for any of the recommendations. The issue of property accountability easily explains the reluctance of AC personnel to allow access to supplies and equipment during non-duty hours while the RC personnel desire access to the AC MTF's supplies and equipment in order to enhance training. The solution to this problem requires a great deal of planning and coordination between the AC MTF and RC unit, such as having an AC present during IDT in order to maintain property accountability or for the RC unit to inventory and sign for supplies and equipment prior to IDT.

The following recommendations had a greater than 40% cumulative Disagree and Strongly Disagree response by both the AC respondents and RC respondents:

"Allow only RC personnel who are formally school trained to perform IDT at AC MTF."

| Respondent | Disagree | Strongly Disagree | Total |
|---|---|---|---|
| AC | 53.8% | 3.8% | 57.6% |
| RC | 46.7% | 3.3% | 50.0% |

"RC personnel should be at an AC MTF only for training and not for utilization purposes."

| Respondent | Disagree | Strongly Disagree | Total |
|---|---|---|---|
| AC | 48.1% | 25.9% | 74% |
| RC | 56.7% | 10.0% | 66.7% |

"RC personnel should be utilized to perform preventive maintenance and repair of AC MTF during non-duty hours."

| Respondent | Disagree | Strongly Disagree | Total |
|---|---|---|---|
| AC | 30.8% | 11.5% | 42.3% |
| RC | 35.7% | 10.7% | 46.4% |

"RC professional personnel should not be utilized for patient care in AC MTF but instead be free to directly supervise and provide "hands-on training" to RC enlisted personnel who are directly involved in patient care."

| Respondent | Disagree | Strongly Disagree | Total |
|---|---|---|---|
| AC | 42.3% | 11.5% | 53.8% |
| RC | 55.2% | 3.4% | 58.6% |

"The AC MTF should utilize RC personnel only for tasks which can be found in an appropriate soldier's manual."

| Respondent | Disagree | Strongly Disagree | Total |
|---|---|---|---|
| AC | 51.9% | 3.7% | 55.6% |
| RC | 38.7% | 6.5% | 45.2% |

"RC personnel should not participate in didactic training while performing IDT at an AC MTF."

| Respondent | Disagree | Strongly Disagree | Total |
|---|---|---|---|
| AC | 33.3% | 14.8% | 48.1% |
| RC | 50.0% | 10.0% | 60% |

## Respondents' AT Recommendations

The following are the recommendations (APPENDIX E) to optimize the training and utilization of RC personnel during AT at AC MTF in descending order of agreement (the higher the mean score, the more negative the response of the respondent panel):

1. Pre-camp conferences need to address more than "housekeeping" functions. Training and utilization issues such as credentials, detailed assignments of personnel, individual and collective tasks, duty hours, etc., need to be discussed. The pre-camp conference should produce a written document, addressing the training and utilization objectives that are agreed upon. (Mean 1.50)

2. Prior to AT, there needs to be a clear delineation of what is expected of the AC MTF and what is expected of the RC personnel. (Mean 1.53)

3. The AC MTF should be provided enough detailed information prior to AT in order to properly utilize and train RC personnel. (Mean 1.55)

4. The AC MTF must develop good orientation and inprocessing methods for RC personnel reporting for AT if optimal training and utilization are to be achieved. (Mean 1.55)

5. RC personnel need to perform AT as sections in accordance with the TO&E. Training/utilization needs to be accomplished with the supervisor and his subordinates to insure quality training. Supervisors need to monitor and record training accomplished during AT. (Mean 1.67)

6. The AC MTF should provide the RC unit with a meaningful evaluation at the completion of AT. The evaluation should be done by personnel who have daily contact with the unit during AT. The evaluation should contain specific recommendations and not just generalities. (Mean 1.67)

7. AT training objectives should be based upon a prior assessment of collective and individual training needs of the RC unit. This data should be analyzed, categorized and prioritized in relation to the unit's mission. (Mean 1.67)

8. RC personnel should be inspected for uniform acquisition, appearance in uniform, height/weight and duty fitness requirements, etc., prior to the commencement of AT. (Mean 1.69)

9. AC MTF planning for the training and utilization of RC personnel during AT needs to include the MTF sections in which the RC personnel will work. (Mean 1.71)

10. AC MTF activities should be notified well in advance by the MTF's PO&T division of RC personnel performing AT in that activity. (Mean 1.76)

11. The AC MTF and RC unit should identify specific soldier manual tasks for each individual that cannot be accomplished during IDT (i.e., 91Ds usually do not have an opportunity to work in an OR during IDT but do during AT). (Mean 1.79)

12. Training to be accomplished during AT should be based upon needs identified in the unit's Yearly Training Plan (YTP). (Mean 1.83)

13. RC augmentation hospitals should emphasize counterpart training. (Mean 1.84)

21. RC augmentation units and their supported AC MTF should practice their mobilization procedures each year during AT. (Mean 2.00)

22. The RC first line supervisor should be held responsible for documenting training received by subordinates during AT. (Mean 2.00)

23. RC Nursing Service representatives should be present during all pre-camp conference planning activities. (Mean 2.02)

24. AC MTF must take more seriously their responsibilities in preparing RC efficiency reports. (Mean 2.03)

25. Whenever possible RC units should be given missions for AT which will maintain section and/or unit integrity. An RC unit for AT could be given the mission of supporting an AC or RC FTX. During AT at an AC MTF, an RC unit could be given the complete responsibility of operating a ward. (Mean 2.07)

26. RC Combat Zone units should only train in an AC MTF every third year. Such units require some training to maintain clinical skills, but require more opportunities to train in the field. (Mean 2.10)

27. AC MTF should assist RC units in gaining proficiency in ARTEP tasks during AT. (Mean 2.19)

28. The AC MTF and RC unit should utilize pre-testing and post-testing to evaluate the effectiveness of task training identified for emphasis during AT. (Mean 2.19)

29. Whenever possible RC Combat Zone units when performing AT at an AC MTF should set up their field equipment next to the MTF. Thus, the RC personnel could gain clinical experience and experience with organic equipment. Minor surgery could be performed utilizing the unit's OR. Dental exams could be accomplished utilizing field equipment. X-ray and

21. RC augmentation units and their supported AC MTF should practice their mobilization procedures each year during AT. (Mean 2.00)

22. The RC first line supervisor should be held responsible for documenting training received by subordinates during AT. (Mean 2.00)

23. RC Nursing Service representatives should be present during all pre-camp conference planning activities. (Mean 2.02)

24. AC MTF must take more seriously their responsibilities in preparing RC efficiency reports. (Mean 2.03)

25. Whenever possible RC units should be given missions for AT which will maintain section and/or unit integrity. An RC unit for AT could be given the mission of supporting an AC or RC FTX. During AT at an AC MTF, an RC unit could be given the complete responsibility of operating a ward. (Mean 2.07)

26. RC Combat Zone units should only train in an AC MTF every third year. Such units require some training to maintain clinical skills, but require more opportunities to train in the field. (Mean 2.10)

27. AC MTF should assist RC units in gaining proficiency in ARTEP tasks during AT. (Mean 2.19)

28. The AC MTF and RC unit should utilize pre-testing and post-testing to evaluate the effectiveness of task training identified for emphasis during AT. (Mean 2.19)

29. Whenever possible, RC Combat Zone units when performing AT at an AC MTF should set up their field equipment next to the MTF. Thus, the RC personnel could gain clinical experience and experience with organic equipment. Minor surgery could be performed utilizing the unit's OR. Dental exams could be accomplished utilizing field

equipment. X-ray and laboratory equipment could be utilized. AC minor illness patients could be cared for on the RC unit's organic wards. (Mean 2.19)

30. RC units and AC MTF should jointly plan FTX. The RC unit can provide field equipment which the MTF does not have and also provide RC personnel to take the place of AC personnel who are participating in FTX. The AC MTF can assist the RC unit by providing expertise not available to the RC unit. (Mean 2.19)

31. RC units which have field environment site support missions should coordinate with an AC MTF for an interchange of personnel. The AC MTF could provide some AC personnel to assist the RC unit in accomplishing its mission and training. The RC unit could provide personnel to replace AC personnel who are in the "field" with the RC unit. (Mean 2.21)

32. The AC MTF should identify services such as a ward, pharmacy, laboratory, dispensary, etc., which RC personnel may perform in their entirety during AT. The RC personnel should work on a side-by-side basis for the first three to five days. Then the operation could be turned over to RC personnel (one AC person should remain for continuity). (Mean 2.24)

33. RC personnel should be allowed to be "in charge" as appropriate over both AC and RC personnel. (Mean 2.26)

34. All personnel requiring licensure or other credentials should bring them to AT. (Mean 2.29)

35. RC personnel who have not completed basic training should not be permitted to come to an AC MTF for AT. (Mean 2.29)

36. Large RC units and/or small AC MTF should not have a single increment for AT. Instead AT should be conducted over a period which allows the AC MTF to adequately utilize and train RC personnel. (Mean 2.34)

37. Judicious utilization of training funds should promote "close to home" AT assignments unless other justification applies. (Mean 2.34)

38. In order to maximize the benefit of the AT period, all credentialing requirements should be forwarded to the MTF three months prior to AT. (Mean 2.38)

39. RC personnel during AT could implement and/or extend the role of the AC MTF in public relations/public health functions. (Mean 2.40)

40. RC medical units do not do a good job of properly training low density non-medical MOS personnel. (Mean 2.40)

41. RC, MC and ANC officers do not need to be trained on how to practice medicine during AT but instead must be trained about the military environment in which they will be expected to function upon mobilization. (Mean 2.40)

42. RC meetings or classes, other than clinical in-services or case presentations, should be scheduled around clinical duty hours (i.e, above the 40 hours of clinical duty per week). (Mean 2.47)

43. The AC MTF should coordinate with RC unit(s) performing AT at the MTF on incremental or year round AT to provide replacements for AC personnel who are on leave, being transferred, attending conferences, etc. (Mean 2.48)

44. If the RC unit's mission upon mobilization is to deploy to the Combat Zone, the RC personnel in this unit should not be utilized or trained in the treatment of OB, pediatric, geriatic, etc., patients. (Mean 2.48)

45. AC MTF should have performance objectives (DA Form 67-8-1) prepared for RC officers assigned to the MTF for AT. These objectives should be the basis of the RC officer's AT OER. (Mean 2.49)

46. Increment/module OICs should not be ANC officers unless that is the individual's mobilization mission. MSC officers can acquire good training while performing this function. (Mean 2.50)

47. Whenever possible, RC personnel should utilize organic patient care TO&E equipment while performing AT at an AC MTF. RC personnel will not have "state-of-the-art" equipment upon mobilization. (Mean 2.53)

48. RC modules should be well balanced in numbers, in experience and in professional and paraprofessional mix. (Mean 2.53)

49. RC physicians should not be utilized independently of other RC personnel in an AC MTF during AT. RC enlisted personnel should be assigned to assist RC physicians. This will enhance the training of RC enlisted personnel. (Mean 2.57)

50. Rotate the assignment of RC personnel each AT. For example, a nurse who was assigned to ward 4C would tend to request 4C each AT. This should be discouraged. (Mean 2.57)

51. The AC MTF should identify and evaluate specific tasks for each RC individual performing AT at the MTF. (Mean 2.60)

52. When an RC unit performs AT at an AC MTF, clinical training should be emphasized. Non-clinical training should be accomplished during IDT. (Mean 2.60)

53. During AT at an AC MTF RC physicians, nurses and other clinicians should be required to rotate through support services such as Logistics, Patient Administration, Personnel, etc., in order to develop an appreciation of the interdependency of all functions within an MTF. (Mean 2.68)

54. Utilize RC medical units to provide medical services during AT to economically depressed areas in CONUS. This could be a fixed facility manned by RC personnel year round. (Mean 2.72)

55. RC personnel should be required to work all shifts and all days of the week during AT in order to maximize training/experience. (Mean 2.74)

56. The AC MTF should anticipate the arrival of RC personnel for AT and increase the MTF workload by scheduling additional patients. (Mean 2.76)

57. RC personnel should not perform AT at an AC MTF within commuting distance of their private practice. (Mean 2.78)

58. RC personnel could be utilized to perform AC MTF TDY requirements such as support of ROTC, Boy Scouts, etc. (Mean 2.79)

59. The AC MTF should solicit projects from its staff for the RC unit(s) to accomplish during AT. (100% property inventories, SOP revisions, research, specialized training, etc.) (Mean 2.81)

60. During AT, RC personnel should be integrated into the AC MTF's duty rosters (MOD, AOD, etc.). (Mean 2.81)

61. AT is for collective training, not individual training. (Mean 2.84)

62. RC units should conduct AT at their designated mobilization site each year. This would increase the time available for training and utilization by eliminating administrative inprocessing and orientation. (Mean 2.84)

63. RC ANC personnel should not be utilized for direct patient care during AT but instead utilized to supervise and train RC enlisted personnel involved in direct patient care. (Mean 3.00)

64. When any RC unit performs AT at an AC MTF, military training should be emphasized because most RC personnel's civilian occupations are medical. (Mean 3.26)

65. Concentrate on individual rather than unit training during AT at an AC MTF. (Mean 3.36)

66. All RC Full-Time Manning (FTM) nursing positions should be filled by AC personnel. (Mean 3.68)

## Analysis of AT Recommendations

The rank ordering of the respondents' AT recommendations in the previous section represents the group concensus of the AC and RC respondents. The higher the rank of the recommendation, the more positive the respondents feel towards its ability to optimize the training and utilization of RC personnel during AT at an AC MTF. The lower the rank of the recommendation, the less positive the respondents feel towards the recommendation's ability to optimize the training and utilization of RC personnel.

The four highest ranked recommendations (lowest means) all address the importance of prior planning and coordination between the AC MTF and the RC unit prior to the commencement of AT. This prior planning and coordination are the keys to optimizing the training and utilization of RC personnel during AT in an AC MTF.

The greatest difference in perceptions between the AC and RC respondents was found in the Likert scale ratings of the following recommendations:

RECOMMENDATION:

"RC units should conduct AT at their designated mobilization site each year. This would increase the time available for training and utilization by eliminating administrative inprocessing and orientation."

DISCUSSION:

Seventy-five point nine percent (75.9%) of the AC respondents Strongly Agree or Agree with this recommendation compared with only 28.6% of the RC respondents. This is a percentage points difference of 47.3. An analysis of the narrative comments associated with this recommendation shows that the RC personnel are more aware of the problems associated with the recommendation. These problems are:

1. Often, the designated mobilization site is not the closest AT site nearest the RC unit. Thus, to go to the unit's designated mobilization site each year would be cost prohibitive.

2. Going to the same mobilization site year after year would not provide the RC personnel with a variety of training experiences.

3. Going to the same mobilization site year after year would not be good for morale or retention of the RC personnel.

RECOMMENDATION:

"AT is for collective training, not individual training."

DISCUSSION:

Fifty percent (50%) of the RC respondents Disagree or Strongly Disagree with this recommendation compared with 38.5% of the AC respondents. This is a percentage points difference of 11.5. This difference of perception is due to FORSCOM's position (i.e, AC) that the RC unit's training program should "come together" at AT. In actuality, however, most RC units train on those tasks that they could not train on during IDT whether they be individual or collective tasks.

RECOMMENDATION:

"The AC MTF should solicit projects from its staff for the RC unit(s) to accomplish during AT (100% property inventories, SOP revisions, research, specialized training, etc.).

DISCUSSION:

Seventy-one point five percent (71.5%) of the AC respondents Strongly Agree or Agree with this recommendation. Only 32.2% of the RC respondents Strongly Agree or Agree with this recommendation. This is a percentage points difference of 34.3. RC personnel don't see AT as a time to do "busy work" such as inventories, etc. They want realistic, challenging training and utilization.

RECOMMENDATION:

"RC personnel should be required to work all shifts and all days of the week during AT in order to maximize training/experience."

DISCUSSION:

Seventy-one point four percent (71.4%) of the RC respondents Strongly Agree or Agree with this recommendation compared with 48.3% of the AC respondents. This is a percentage points difference of 23.1. This is indicative of the RC personnel's desire to be fully integrated into the AC MTF to the greatest extent possible. The RC are far more cognitive of the "One Army" concept than the AC.

RECOMMENDATION:

"During AT, RC personnel should be integrated into the AC MTF's duty rosters (MOD, AOD, etc.)."

DISCUSSION:

Sixty-seven point nine percent (67.9%) of the RC respondents Strongly Agree or Agree with this recommendation compared to 44.8% of the AC respondents. This is a percentage points difference of 23.1. Once again, the RC personnel want to be fully integrated into the operation of the AC MTF.

The following recommendations had a greater than 40% cumulative Disagree and Strongly Disagree response by both the AC respondents and RC respondents.

"Concentrate on individual rather than unit training during AT at an AC MTF."

| Respondent | Disagree | Strongly Disagree | Total |
|---|---|---|---|
| AC | 41.4% | 6.9% | 48.3% |
| RC | 46.4% | 14.3% | 60.7% |

"All RC Full-Time Manning (FTM) nursing positions should be filled by AC personnel."

| Respondent | Disagree | Strongly Disagree | Total |
|---|---|---|---|
| AC | 28.6% | 28.6% | 57.2% |
| RC | 57.1% | 17.9% | 75% |

"RC ANC personnel should not be utilized for direct patient care during AT but instead utilized to supervise and train RC enlisted personnel involved in direct patient care."

| Respondent | Disagree | Strongly Disagree | Total |
|---|---|---|---|
| AC | 28.6% | 14.3% | 42.9% |
| RC | 46.4% | 0 | 46.4% |

"When any RC unit performs AT at an AC MTF, military training should be emphasized because most RC personnel's civilian occupations are medical."

| Respondent | Disagree | Strongly Disagree | Total |
|---|---|---|---|
| AC | 44.8% | 3.4% | 48.2% |
| RC | 50.0% | 7.1% | 57.1% |

"RC personnel could be utilized to perform AC MTF TDY requirements such as support of ROTC, Boy Scouts, etc."

| Respondent | Disagree | Strongly Disagree | Total |
|---|---|---|---|
| AC | 24.1% | 17.2% | 41.3% |
| RC | 35.7% | 7.1% | 42.8% |

## IV. CONCLUSION

The recommendations of the respondent panel support the thesis that meaningful utilization of RC personnel in AC MTF is excellent training. The critical factors necessary for meaningful training and utilization are indepth planning and coordination by both the RC unit and the AC MTF. But, far too often, indepth planning and coordination do not take place. Usually, there is minimal dialogue between the RC unit and AC MTF.

Successful RC training and utilization in an AC MTF have its foundation in the RC unit's analysis of its mobilization mission. From this analysis, the RC unit specifically identifies which collective and individual tasks require the environment of the AC MTF for training in these tasks. The RC unit also needs to specifically identify tasks to be trained during each IDT and AT period utilizing its organic chain of command as much as possible.

In addition to this analysis and planning of training, the RC unit and AC MTF must develop a continuous dialogue which results in the optimization of the RC unit's training requirements and the AC MTF's utilization requirements. This coordination should result in a written document which delineates the responsibilities of the RC unit and AC MTF. Mechanisms need to be established which provide feedback on the success in obtaining the objectives of the RC unit and AC MTF. When the objectives of either party are not being met, both parties need to negotiate a solution. This requires a frequent interchange between the RC

unit's and AC MTF's personnel who are involved in the training and utilization process.

## V. RECOMMENDATIONS FOR FUTURE STUDY

This study did not focus on the training and utilization of any specific type of RC unit. As the study developed, it became evident that the training and utilization of RC augmentation units have different requirements than the training and utilization of RC TO&E units. It is recommended that future study in this area concentrate on the specific needs of RC augmentation units and/or the specific needs of RC TO&E units.

Also, it is recommended that the Undecided response not be utilized with the Likert scale. This would assist the research effort by forcing the respondents to make a decision specifically for or against a recommendation.

# APPENDIX A

## DEFINITIONS

1. IDT: Individual Training. This term is used to designate training conducted by RC personnel during monthly drill periods. This can be over one weekend a month, week nights or any combination which equals 16 hours.

2. AT: Annual Training. AT is the two weeks of training required each year of RC personnel. This requirement can be done in many different types of increments in accordance with mission and needs of unit.

3. Delphi Technique: A technique where a group of experts is asked for their opinions in an environment in which all of them individually have access to each other's information but in which the majority opinion is not disclosed to prevent it from unduly influencing anyone.

4. RC: Reserve Component. Term used to designate both U.S. Army Reserve and Army National Guard personnel.

5. ARMR: Army Readiness Mobilization Region. An active component organization commanded by a Major General who has responsibility for commanding USAR units and advising ARNG units in a multiple state area. An ARMR is a major subordinate command of CONUS Army command.

6. MOBDES: Mobilization Designee. An RC individual who has a specific position to fill upon mobilization. A MOBDES does not belong to a specific RC troop unit. A MOBDES performs AT with the AC unit he will report to upon mobilization.

7. Readiness Group: An active component organization responsible for advising USAR and ARNG units. Commanded by combat arms Colonel (O-6). A Readiness Group is a major subordinate organization of an ARMR.

8. IMA: Individual mobilization augmentee. New term for MOBDES.

9. Dedicated Advisors. AC personnel assigned to a specific RC unit to advise that unit. These AC personnel are not assigned to a Readiness Group.

10. Augmentees. AC personnel assigned to specific TOE positions in an RC unit. An augmentee is a mobilization asset of that RC unit.

11. OTSG. Office of The Surgeon General.

# APPENDIX B

DEPARTMENT OF THE ARMY
HEADQUARTERS, US ARMY READINESS
AND MOBILIZATION REGION II, FIRST US ARMY
FORT DIX, NEW JERSEY 08640

SUBJECT: Utilization and Training of Reserve Component (RC) Personnel in Action Component (AC) Medical Treatment Facilities.

16 NOV 1983

TO WHOM IT MAY CONCERN:

There is a need for research in the area of utilization and training of Reserve Component Personnel in Active Component Medical Treatment Facilities. Approximately 68-72% of medical mobilization assets are in the United States Army Reserves. The vast majority of RC personnel have very limited hands-on experience and are not MOS qualified. Better utilization and training of RC personnel would greatly increase readiness status of medical units. It would also create a better rapport between AC and RC medical personnel. Research in this area will provide information that will fill the gap that now exists between AC and RC medical personnel and assist in solving problems active component, advisors, branch assistors and readiness coordinators experience in providing worthwhile annual training for RC units.

Roosevelt D. Butler

ROOSEVELT D. BUTLER
COL, MSC
MED REDCOORD-USARMR II
C, Cbt Svc Spt Bn

APPENDIX C

DEPARTMENT OF THE ARMY
ACADEMY OF HEALTH SCIENCES, UNITED STATES ARMY
FORT SAM HOUSTON, TEXAS 78234

REPLY TO
ATTENTION OF:

HSHA-ZNG

13 December 1983

SUBJECT: Utilization of Reserve Component Personnel in Medical Treatment Facilities

MAJ Brian Foley
Administrative Resident
Fitzsimmons Army Medical Center
Aurora, CO 80045

1. For a number of years Reserve Component personnel have trained at Active Army medical treatment facilities. These individuals have trained both in a one-on-one status and as members of their units. They represented Individual Mobilization Augmentees, Individual Ready Reservists and troop program unit members. The training they have received has been as varied as the many installations at which they have trained.

2. Despite the fact that this program has been ongoing for a long period of time and that it has involved a very large number of Reserve Component personnel, there has never been any formal study to determine the effects of this type of training on the Mobilization Readiness of the Reserve Components.

3. Your efforts to conduct research in this area are to be commended. We look forward to the opportunity to participate in the study and we are anxious to share the results of your work.

Dennis P. McKnight

DENNIS P. McKNIGHT
LTC, MSC
ARNG Advisor

# APPENDIX D

DEPARTMENT OF THE ARMY
FITZSIMONS ARMY MEDICAL CENTER
AURORA, COLORADO 80045

REPLY TO
ATTENTION OF

HSHG-ZX

SUBJECT: Utilization and Training of Reserve Component Personnel (RC) in Active Component (AC) Army Medical Treatment Facilities (MTF)

1. I am conducting research in the best methods of utilizing and training RC personnel in AC Army MTF. With your assistance, it is hoped that recommendations can be developed that will enhance the role of RC personnel in the accomplishment of Army MTF missions. Conversely, it is hoped that better methods of enhancing the training of RC personnel while they assist the Active Components in the MTF can be discovered.

2. This study is being conducted using the Delphi Technique. This is a technique where a group of experts is asked for their opinions in an environment in which all of them individually have access to each other's information but in which individual opinions are not disclosed to prevent them from influencing anyone unduly. This will be accomplished by a series of questionnaires. This first questionnaire is open-ended concerning the utilization and training of RC personnel. After the recommendations from the first questionnaire have been edited and summarized, you will receive a second questionnaire asking you to review the recommendations and rank them in order of priority. The results of the second questionnaire will be edited and summarized again and you will receive a third questionnaire. The third questionnaire will ask you to rank each item for a final time in light of the emerging pattern of group consensus and give any final comments on each item. Upon compilation of the final recommendations, you will receive a copy in recognition of your efforts.

3. It is realized that the issues of utilization and training of RC personnel in AC MTF are mutually dependent. (That is the training, both individual and collective, must be an integral part of the support of an MTF.) In the Delphi questionnaire, these two issues have been broken out in order to insure that both the topics are addressed.

4. You have been requested to participate in this study because of your particular expertise. A cross sample of AC and RC personnel are being asked to participate in this study (i.e., Army surgeons, ARMR medical coordinators, Readiness Group personnel, advisors, AT and RC Commanders, Executive Officers, Chief, Professional Services, Nursing personnel, Chief, Plans, Operations and Training, Command Sergeant Major, etc.).

QUESTIONNAIRE #1 (A)

Code _____ Date _____

Please list recommendations for improving the utilization of RC personnel during IDT (weekends/week nights; i.e., the monthly drill) that will enhance the capabilities and services of AC MTF. For each of your recommendations, please put in the right hand column explanations or examples. This explanation should be brief but should demonstrate why the recommendation is important.

| RECOMMENDATION | EXPLANATION/EXAMPLE |
| --- | --- |
| | |

| RECOMMENDATION | EXPLANATION/EXAMPLE |
| --- | --- |
| | |

QUESTIONNAIRE #1 (B)

Code _____

Date _____

Please list recommendations for improving the utilization of RC personnel during AT (two-week annual training) that will enhance the capabilities and services of AC MTF. For each of your recommendations, please put in the right hand column explanations or examples. The explanations or examples should be brief but should demonstrate why the recommendations are important.

| RECOMMENDATION | EXPLANATION/EXAMPLE |
| --- | --- |
| | |

| RECOMMENDATION | EXPLANATION/EXAMPLE |
| --- | --- |
| | |

QUESTIONNAIRE #1 (C)

Code _____

Date _____

Please list recommendations for improving the individual and collective training of RC personnel working in AC MTF during IDT (monthly drill period). For each of your recommendations, please put brief explanations in the right hand columns. Explanations should demonstrate why the recommendation is important.

| RECOMMENDATION | EXPLANATION/EXAMPLE |
| --- | --- |
| | |

| RECOMMENDATION | EXPLANATION/EXAMPLE |
| --- | --- |
| | |

QUESTIONNAIRE #1 (D)

Code _____ Date _____

Please list recommendations for improving the individual and collective training of RC personnel working in AC MTF during AT (two-week annual training). For each of your recommendations, please put in the right hand column explanations or examples. These explanations should be brief but should demonstrate why the recommendation is important.

| RECOMMENDATION | EXPLANATION/EXAMPLE |
| --- | --- |
| | |

| RECOMMENDATION | EXPLANATION/EXAMPLE |
| --- | --- |
| | |

# APPENDIX E

DEPARTMENT OF THE ARMY
FITZSIMONS ARMY MEDICAL CENTER
AURORA, COLORADO 80045

REPLY TO ATTENTION OF
HSHG-ZX

26 MAR 1984

SUBJECT: Questionnaire #2 - Utilization and Training of RC in AC Army MTF

1. Thank you for your efforts in responding to Questionnaire #1. Your participation in this study in light of the many demands upon your time is greatly appreciated.

2. Because of the quantity and complexity of the recommendations received from the first questionnaire, I plan to change my research methodology. As stated in my first letter to you, the purpose of this study is to discover methods to optimize both RC utilization and training in AC MTF. This is best accomplished by finding activities which will simultaneously provide training to the RC personnel and utilization for the AC MTF. In order to accomplish this, the recommendations for IDT training and IDT utilization have been merged into recommendations for activities which RC personnel can perform in an AC MTF which provide both optimal IDT training and utilization simultaneously. The recommendations for AT training and AT utilization have also been merged into recommendations which combine optimum AT training and utilization.

3. Request that you express your opinion on the graphic rating scale for each recommendation's ability to optimize RC training and utilization. Please feel free to make a narrative comment on any of the recommendations.

4. Please return the questionnaire NLT 15 APR 1984 in the inclosed self-addressed, stamped envelope. Your prompt return of the attached questionnaire is important to the validity of the study.

5. Once again, thank you for your participation in the study. Because of my change in research methodology, I will not be sending you a third questionnaire. As I promised in the first questionnaire, you will receive a copy of the final report. If you have any questions, you may contact me at commercial: (303) 361-8313; Autovon: 943-8313; or FTS: 337-8313.

2 Inclosures
As stated

BRIAN P. FOLEY
Major, MSC
Administrative Resident

IDT RC UTILIZATION AND TRAINING IN AC MTF

#_____

Please circle your opinion on the graphic rating scale for each recommendation's ability to optimize IDT training and utilization.

(Strongly agree = SA; Agree = A; Undecided = U; Disagree = D; Strongly Disagree = SD)

1. The AC MTF should credential RC physicians (MC), nurses (ANC) and enlisted technicians (91D) to perform surgery and elective surgery should be scheduled for them on week nights and weekends.

SA A U D SD

Comment:

2. RC personnel would receive better training and the AC MTF greater utilization if IDT were not limited to weekends. Greater effort should be made between the RC units and the AC MTF to allow RC personnel to perform IDT during normal duty hours and on week nights.

SA A U D SD

Comment:

3. RC personnel should perform IDT not only during the day shift but also during the evening and night shifts.

SA A U D SD

Comment:

4. The AC MTF should give the RC unit (within its capabilities) missions to accomplish such as totally operate a clinic, ward, pharmacy, physical exam service, perform inventories, write plans, etc.

SA A U D SD

Comment:

5. Each AC MTF should have its own RC augmentation unit. The TDA of this RC augmentation unit would specifically match the positions in the AC MTF which will require "back filling" upon mobilization.

SA A U D SD

Comment:

6. RC personnel should only function, in the AC MTF, in the MOS which they are assigned against the RC unit's TOE. During IDT they should not be utilized based on civilian acquired expertise if it is not their duty upon mobilization.

SA A U D SD

Comment:

7. Careful coordination is required between the AC MTF and the RC unit to insure that the MTF does not have an excess of staff on duty.

SA A U D SD

Comment:

8. RC units must insure that they do not inundate the AC MTF with more personnel than can be given hands-on experience.

SA A U D SD

Comment:

9. An hour each day during IDT should be established for in-service training utilizing the AC MTF audio-visual equipment and video tape library.

SA A U D SD

Comment:

10. Only allow RC personnel that can actually benefit from the training at an AC MTF perform IDT at an AC MTF.

SA A U D SD

Comment:

11. Only allow RC personnel who are formally school trained to perform IDT at AC MTF.

SA A U D SD

Comment:

12. RC personnel should be at an AC MTF only for training and not for utilization purposes.

SA A U D SD

Comment:

13. The AC MTF should schedule patients specifically for treatment by RC personnel during IDT periods.

SA A U D SD

Comment:

14. RC personnel should be integrated into the AC MTF duty rosters for ACD, MOD, Chaplain-on-call, social worker on-call, etc. Individuals pulling these duties would receive credit for IDT.

SA A U D SD

Comment:

15. During weekend IDT RC units should be responsible for 24-hour operations.

SA A U D SD

Comment:

16. RC physicians should be credentialed and integrated into the AC medical staff. These RC physicians could receive IDT credit for consulting, diagnostic procedures, and patient treatment. These RC physicians would integrate their responsibilities at the AC MTF into their private practice in the same manner as they do in civilian hospitals.

SA A U D SD

Comment:

17. RC personnel should not participate in didactic training while performing IDT at an AC MTF.

SA A U D SD

Comment:

18. RC personnel should be required to remain for a full shift when assigned to a nursing unit and not pulled out for administrative matters or training at the RC unit.

SA A U D SD

Comment:

19. RC personnel should be fully integrated with AC personnel in the AC MTF. The RC personnel should be allowed to do the same tasks as their AC counterparts.

SA A U D SD

Comment:

20. RC enlisted personnel such as 91D, 91E, 91G, 91H, 91P, 91Q, 91X and 35G could be integrated into the AC MTF on call roster and receive IDT credit for this duty.

SA A U D SD

Comment:

21. RC personnel should be utilized for "batch processing" at night or weekends for the processing of laboratory samples, x-rays, computer data processing, filing of medical records, etc.

SA A U D SD

Comment:

22. RC personnel should be utilized to perform preventive maintenance and repair of AC MTF equipment during non-duty hours.

SA A U D SD

Comment:

23. AC MTF should allow access for RC personnel to equipment and supplies (x-ray, dental lab) not normally operational during IDT periods.

SA A U D SD

Comment:

24. An RC unit should not schedule all of its personnel at the AC MTF for one weekend a month. Each weekend of the month should be utilized in order to provide better training to RC personnel and better utilization by the AC MTF.

SA A U D SD

Comment:

25. RC blood bank personnel should provide blood collecting services on weekends and week nights in order to provide a source of after hour blood collecting.

SA A U D SD

Comment:

26. RC personnel should be utilized to relieve AC personnel from non-duty hour ER duty.

SA A U D SD

Comment:

27. RC personnel should be given the mission of training AC personnel (EFMB, NCODP, SQT, in-service nursing education, CME, etc.).

SA A U D SD

Comment:

28. AC MTF personnel should be utilized to train RC trainees--"train the trainer".

SA A U D SD

Comment:

29. RC professional personnel should not be utilized for patient care in AC MTF but instead be free to directly supervise and provide "hands-on training" to RC enlisted personnel who are directly involved in patient care.

SA A U D SD

Comment:

30. BTMS principles are extremely important in the training and utilization of RC personnel in AC MTF.

SA A U D SD

Comment:

31. All training at AC MTF should be geared towards the RC unit's mobilization mission.

SA A U D SD

Comment:

32. The utilization and training of RC personnel in AC MTF should include duties normally performed by DACs, such as: medical record abstracting and coding, Treasurer's Office, etc.

SA A U D SD

Comment:

33. RC personnel should be assigned different soldier manual tasks for teaching and testing each IDT period.

SA A U D SD

Comment:

34. RC personnel should be required to have their "Job Book" during IDT at an AC MTF.

SA A U D SD

Comment:

35. The basis of all RC utilization and training at an AC MTF is the RC unit's Yearly Training Plan (YTP).

SA A U D SD

Comment:

36. The AC MTF should utilize RC personnel only for tasks which can be found in an appropriate soldier's manual.

SA A U D SD

Comment:

37. Stabilize RC personnel so that they work in the same position for at least one year.

SA A U D SD

Comment:

38. RC personnel should be rotated among various jobs. RC personnel should not perform the same job (i.e., physical exam, ER, ward) year after year.

SA A U D SD

Comment:

39. If the RC unit is given a mission such as operating a clinic or conducting physical exams, the unit should not be booked solid. The unit should have enough time to train its personnel as the mission is being accomplished.

SA A U D SD

Comment:

40. RC personnel should be utilized during IDT to provide services to eligible beneficiaries that are not normally available such as dental care to dependents.

SA A U D SD

Comment:

41. All RC personnel who utilize an AC facility for IDT should be formally trained by the AC MTF in Hospital and Fire Safety, Infection Control, IV Therapy, CPR, medical record documentation, etc.

SA A U D SD

Comment:

42. RC personnel performing IDT at AC MTF should be required to meet AC appearance, weight and physical fitness requirements.

SA A U D SD

Comment:

43. Allow RC personnel in supervisory grades/positions to do the work that is commensurate with their grade/position. Give them the responsibility and authority to get a job and mission done.

SA A U D SD

Comment:

44. When more than one RC person performs simultaneous IDT, one should be designated as "in charge" and should be responsible for the training of the other.

SA A U D SD

Comment:

45. RC personnel performing IDT in an AC MTF should not be utilized as individuals but instead as part of a section or team of the RC unit (i.e., utilize RC personnel in accordance with RC chain of command).

SA A U D SD

Comment:

46. Allow qualified RC personnel to assume OIC and NCOIC positions to include supervision of AC personnel.

SA A U D SD

Comment:

47. Instead of weekends IDT should be performed on successive week night evenings in order for RC personnel to assure the responsibility and continuity necessary to perform duties in a clinic, ward, OR, etc.

SA A U D SD

Comment:

48. The RC unit must provide the AC MTF with a clear statement of the RC unit's mobilization mission, training requirements and capabilities.

SA A U D SD

Comment:

49. If the AC MTF can't provide training in required tasks, the AC MTF should not be utilized for IDT.

SA A U D SD

Comment:

50. RC units should utilize organic equipment during IDT at AC MTF as much as possible. For example, utilize tents and organic x-ray, laboratory equipment to perform physical examinations, dental procedures, etc.

SA A U D SD

Comment:

51. RC utilization and training in AC MTF should be geared toward the RC unit's mobilization mission.

SA A U D SD

Comment:

52. The AC MTF should make available to the RC unit classroom space and audio-visual equipment.

SA A U D SD

Comment:

53. Medical record documentation is a major problem for RC personnel. RC units should hold specific classes on this subject in the unit prior to IDT assignment.

SA A U D SD

Comment:

54. RC personnel should be utilized for week day early morning duties such as blood collecting, vital signs, etc. This would allow some RC personnel to perform IDT prior to commencement of their civilian job.

SA A U D SD

Comment:

55. AC MTF personnel should maintain close contract/dialogue with the RC unit whose personnel do training at the AC MTF. AC MTF personnel should, on occasion, visit the RC unit to gain first hand knowledge of the RC unit's staff and to brief the staff on the progress of RC personnel performing IDT at the AC MTF. AC MTF supervisors and staff should be available in their duty sections on occasion during IDT to reinforce the "One Army Concept".

SA A U D SD

Comment:

56. There should be scheduled quarterly meetings between AC MTF personnel (PO&T, Department of Nursing, etc.) and the RC unit(s) performing IDT at the MTF. A continuous dialogue will assist the communication process.

SA A U D SD

Comment:

57. RC personnel should be assigned to a specific clinical area on a regular basis for at least six months. During this IDT period the individual should not be called back to the unit.

SA A U D SD

Comment:

58. The AC MTF and the RC unit(s) performing IDT at the MTF should have a written memorandum of agreement (MOU) specifically outlining the responsibilities of the AC and RC.

SA A U D SD

Comment:

59. The AC MTF must assume a responsibility in the evaluation of RC training performed at its facility.

SA A U D SD

Comment:

60. RC personnel should always be trained at the AC MTF and not just used as bodies.

SA A U D SD

Comment:

61. The AC MTF should have input into the efficiency ratings of RC personnel who regularly perform IDT at the facility.

SA A U D SD

Comment:

62. The AC MTF and RC unit must conduct detailed planning before the commencement of IDT training at the facility.

SA A U D SD

Comment:

63. AC personnel do not display enough interest in RC affairs.

SA A U D SD

Comment:

64. The AC MTF should establish a sponsorship program for RC personnel who perform IDT at the MTF (i.e., an AC wardmster sponsor an RC wardmaster, etc.).

SA A U D SD

Comment:

65. AC MTF personnel should participate as trainers in the FTX exercises of the RC unit(s) who perform IDT at the facility.

| SA | A | U | D | SD |
|---|---|---|---|---|

Comment:

66. The RC needs to be more selective in the utilization of AC MTF for IDT.

| SA | A | U | D | SD |
|---|---|---|---|---|

Comment:

AT RC UTILIZATION AND TRAINING IN AC MTF

#_____

Please circle your opinion on the graphic rating scale for each recommendation's ability to optimize AT training and utilization.

(Strongly Agree = SA; Agree = A; Undecided = U; Disagree = D, Strongly Disagree = SD)

1. RC units should conduct AT at their designated mobilization site each year. This would increase the time available for training and utilization by eliminating administrative inprocessing and orientation.

SA A U D SD

Comment:

2. Whenever possible RC units should be given missions for AT which will maintain section and/or unit integrity. An RC unit for AT could be given the mission of supporting an AC or RC FTX. During AT at an AC MTF, an RC unit could be given the complete responsibility of operating a ward.

SA A U D SD

Comment:

3. AT is for collective training, not individual training.

SA A U D SD

Comment:

4. RC personnel need to perform AT as sections in accordance with the TOAE. Training/utilization needs to be accomplished with the supervisor and his subordinates to insure quality training. Supervisors need to monitor and record training accomplished during AT.

SA A U D SD

Comment:

5. RC medical units do not do a good job of properly training low density non-medical MOS personnel.

SA A U D SD

Comment:

6. Concentrate on individual rather than unit training during AT at an AC MTF.

SA A U D SD

Comment:

7. Large RC units and/or small AC MTF should not have a single increment for AT. Instead AT should be conducted over a period which allows the AC MTF to adequately utilize and train RC personnel.

SA A U D SD

Comment:

8. When an RC unit can't perform AT in a single increment, it should assign personnel to increments by TOE section/team. This will allow the organic leadership of the RC unit to function and enhance collective training. When an AC MTF can't absorb an entire TOE section/team unit, integrity should be maintained as much as possible (i.e., half section one increment, the other half the next increment).

SA A U D SD

Comment:

9. Rotate the assignment of RC personnel each AT. For example, a nurse who was assigned to ward 4C would tend to request 4C each AT. This should be discouraged.

SA A U D SD

Comment:

10. The AC MTF should coordinate with RC unit(s) performing AT at the MTF on incremental or year round AT to provide replacements for AC personnel who are on leave, being transferred, attending conferences, etc.

SA A U D SD

Comment:

11. In order to maximize the benefit of the AT period all credentialing requirements should be forwarded to the MTF three months prior to AT.

SA A U D SD

Comment:

12. All RC FTM nursing positions should be filled by AC personnel.

SA A U D SD

Comment:

13. RC personnel should be allowed to be "in charge" as appropriate over both AC and RC personnel.

SA A U D SD

Comment:

14. RC individuals should bring lists of goals, objectives, etc., to be accomplished during AT.

SA A U D SD

Comment:

15. RC personnel should be inspected for uniform acquisition, appearance in uniform, height/weight and duty fitness requirements, etc., prior to the commencement of AT.

SA A U D SD

Comment:

16. Increment/module OICs should not be ANC officers unless that is the individual's mobilization mission. ANC officers can acquire good training while performing this function.

SA A U D SD

Comment:

17. RC modules should be well balanced in numbers, in experience and in professional and paraprofessional mix.

SA A U D SD

Comment:

18. All personnel requiring licensure or other credentials should bring them to AT.

SA A U D SD

Comment:

19. Judicious utilization of training funds should promote "close to home" AT assignments unless other justification applies.

SA A U D SD

Comment:

20. RC personnel assignments in an AC MTF should be based first on the training needs of the RC personnel and secondly on utilization requirements.

SA A U D SD

Comment:

21. AC MTF should assist RC units in gaining proficiency in ARTEP tasks during AT.

SA A U D SD

Comment:

22. The AC MTF should solicit projects from its staff for the RC unit(s) to accomplish during AT. (100% property inventories, SOP revisions, research, specialized training, etc.)

SA A U D SD

Comment:

23. RC ANC personnel should not be utilized for direct patient care during AT but instead utilized to supervise and train RC enlisted personnel involved in direct patient care.

SA A U D SD

Comment:

24. RC, MC and ANC officers do not need to be trained on how to practice medicine during AT but instead must be trained about the military environment in which they will be expected to function upon mobilization.

SA A U D SD

Comment:

25. During AT at an AC MTF RC physicians, nurses and other clinicians should be required to rotate through support services such as Logistics, Patient Administration, Personnel, etc., in order to develop an appreciation of the interdependency of all functions within an MTF.

SA A U D SD

Comment:

26. RC units and AC MTF should jointly plan FTX. The RC unit can provide field equipment which the MTF does not have and also provide RC personnel to take the place of AC personnel who are participating in FTX. The AC MTF can assist the RC unit by providing expertise not available to the RC unit.

SA A U D SD

Comment:

27. Whenever possible RC personnel should utilize organic patient care TOE equipment while performing AT at an AC MTF. RC personnel will not have "state-of-the-art" equipment upon mobilization.

SA A U D SD

Comment:

28. The AC MTF should be provided enough detailed information prior to AT in order to properly utilize and train RC personnel.

SA A U D SD

Comment:

29. RC personnel should be required to work all shifts and all days of the week during AT in order to maximize training/experience.

SA A U D SD

Comment:

30. RC meetings or classes, other than clinical in-services or case presentations, should be scheduled around clinical duty hours (i.e., above the 40 hours of clinical duty per week).

SA A U D SD

Comment:

31. The AC MTF and RC unit should identify specific soldier manual tasks for each individual that can't be accomplished during IDT (i.e., 91Ds usually do not have an opportunity to work in an OR during IDT but do during AT).

SA A U D SD

Comment:

32. The AC MTF should identify and evaluate specific tasks for each RC individual performing AT at the MTF.

SA A U D SD

Comment:

33. RC personnel should not perform AT at an AC MTF within commuting distance of their private practice.

SA A U D SD

Comment:

34. The RC first line supervisor should be held responsible for documenting training received by subordinates during AT.

SA A U D SD

Comment:

35. Utilize RC medical units to provide medical services during AT to economically depressed areas in CONUS. This could be a fixed facility manned by RC personnel year round.

SA A U D SD

Comment:

36. The AC MTF should anticipate the arrival of RC personnel for AT and increase the MTF workload by scheduling additional patients.

SA A U D SD

Comment:

37. Training to be accomplished during AT should be based upon needs identified in the unit's Yearly Training Plan (YTP).

SA A U D SD

Comment:

38. Prior to AT there needs to be a clear delineation of what is expected of the AC MTF and what is expected of the RC personnel.

SA A U D SD

Comment:

39. Provide RC personnel with the AC MTF standard Welcome Packet prior to AT.

SA A U D SD

Comment:

40. AC MTF activities should be notified well in advance by the MTF's PO&T division of RC personnel performing AT in that activity.

SA A U D SD

Comment:

41. AC MTF should have performance objectives (DA Form 67-8-1) prepared for RC officers assigned to the MTF for AT. These objectives should be the basis of the RC officer's AT OER.

SA A U D SD

Comment:

42. The AC MTF must develop good orientation and inprocessing methods for RC personnel reporting for AT if optimal training and utilization is to be achieved.

SA A U D SD

Comment:

43. Pre-camp conferences need to address more than "housekeeping" functions. Training and utilization issues such as credentials, detailed assignments of personnel, individual and collective tasks, duty hours, etc., need to be discussed. The pre-camp conference should produce a written document, addressing the training and utilization objectives that are agreed upon.

SA A U D SD

Comment:

44. AT training objectives should be based upon a prior assessment of collective and individual training needs of the RC unit. This data should be analyzed, categorized and prioritized in relation to the unit's mission.

SA A U D SD

Comment:

45. RC Nursing Service representatives should be present during all pre-camp conference planning activities.

SA A U D SD

Comment:

46. The RC unit should analyze the continued omission of training objectives still present after repeated AT at an AC MTF.

SA A U D SD

Comment:

47. A brief but formalized plan needs to be in the hands of all AC MTF supervisory personnel. This document would delineate specifically the AT training and utilization objectives which have been developed between the RC unit and the MTF.

SA A U D SD

Comment:

48. AC MTF planning for the training and utilization of RC personnel during AT needs to include the MTF sections in which the RC personnel will work.

SA A U D SD

Comment:

49. If the RC unit's mission upon mobilization is to deploy to the Combat Zone, the RC personnel in this unit should not be utilized or trained in the treatment of OB, pediatric, geriatric, etc., patients.

SA A U D SD

Comment:

50. RC augmentation units and their supported AC MTF should practice their mobilization procedures each year during AT.

SA A U D SD

Comment:

51. RC Combat Zone units should only train in an AC MTF every third year. Such units require some training to maintain clinical skills, but require more opportunities to train in the field.

SA A U D SD

Comment:

52. Whenever possible RC Combat Zone units when performing AT at an AC MTF should set up their field equipment next to the MTF. Thus, the RC personnel could gain clinical experience and experience with organic equipment. Minor surgery could be performed utilizing the unit's OR. Dental exams could be accomplished utilizing field equipment. X-ray and laboratory equipment could be utilized. AC minor illness patients could be cared for on the RC unit's organic wards.

SA A U D SD

Comment:

53. When an RC unit performs AT at an AC MTF, clinical training should be emphasized. Non-clinical training should be accomplished during IDT.

SA A U D SD

Comment:

54. When any RC unit performs AT at an AC MTF, military training should be emphasized because most RC personnel's civilian occupations are medical.

SA A U D SD

Comment:

55. RC augmentation hospitals should emphasize counterpart training.

SA A U D SD

Comment:

56. The AC MTF should identify services such as a ward, pharmacy, laboratory, dispensary, etc., which RC personnel may perform in their entirety during AT. The RC personnel should work on a side-by-side basis for the first three to five days. Then the operation could be turned over to RC personnel (one AC person should remain for continuity).

SA A U D SD

Comment:

57. During AT RC personnel should be integrated into the AC MTF's duty rosters (NOD, ACD, etc.).

SA A U D SD

Comment:

58. RC units which have field environment site support missions should coordinate with an AC MTF for an interchange of personnel. The AC MTF could provide some AC personnel to assist the RC unit in accomplishing its mission and training. The RC unit could provide personnel to replace AC personnel who are in the "field" with the RC unit.

SA A U D SD

Comment:

59. RC personnel during AT could implement and/or extend the role of the AC MTF in public relations/public health functions.

SA A U D SD

Comment:

60. RC personnel could be utilized to perform AC MTF TDY requirements such as support of ROTC, Boy Scouts, etc.

SA A U D SD

Comment:

61. AC MTF must take more seriously their responsibilities in preparing RC efficiency reports.

SA A U D SD

Comment:

62. RC personnel who have not completed basic training should not be permitted to come to an AC MTF for AT.

SA A U D SD

Comment:

63. Periodic assessments of RC performance should be conducted during AT by both AC MTF and RC unit staff. This would allow for correction of problem areas as they occur and circumvent any discord that could result from poor communication. Waiting until the last few days of AT does not allow for the opportunity to effect change.

SA A U D SD

Comment:

64. The AC MTF should provide the RC unit with a meaningful evaluation at the completion of AT. The evaluation should be done by personnel who have daily contact with the unit during AT. The evaluation should contain specific recommendations and not just generalities.

SA A U D SD

Comment:

65. The AC MTF and RC unit should utilize pre-testing and post-testing to evaluate the effectiveness of task training identified for emphasis during AT.

SA A U D SD

Comment:

66. RC physicians should not be utilized independently of other RC personnel in an AC MTF during AT. RC enlisted personnel should be assigned to assist RC physicians. This will enhance the training of RC enlisted personnel.

SA A U D SD

Comment:

# APPENDIX F

ACTIVE COMPONENT (AC) RESPONDENTS

ARMR Medical Readiness Coordinators (2 req/2 completed)

COL R. Butler, MSC, Medical Readiness Coordinator, ARMR II, Ft Dix, NJ
COL Wood, MSC, Medical Readiness Coodinator, ARMR VIII, FAMC, Aurora, CO

Readiness Group Medical Team Representatives (3 req/3 completed)

LTC J. Foster, C, Medical Team, Readiness Group - Denver, FAMC, Aurora, CO
CPT B. Baldwin, MSC, Readiness Group - Fort Riley, KS
C, Medical Team, Readiness Group - Fort Stewart, Newburg, N.Y.

Dedicated RC Advisors/Augmentees (3 req/3 completed)

LTC D. Hull, MSC, Senior Advisor, 127th Medical Group, Ashland, AL
LTC J. Kamenar, MSC, Senior Medical Advisor, Sixth US Army, Presidio of San Francisco, CA
MAJ G. Turner, MSC, Medical Advisor, Colorado National Guard

AC MTF Department of Nursing Repesentative(s) (2 req/3 completed)

LTC Webster, ANC, DeWitt Army Hospital, Fort Belvoir, VA
MAJ D. Corcoran, ANC, C, NETS, Fitzsimons Army Medical Center, Aurora, CO
C, Dept of Nursing, Blanche Field Army Hospital, Fort Campbell, KY

AC MTF POT Representative(s) (2 req/3 completed)

COL F. Mills, MSC, Dir of PT&S, Fitzsimons Army Medical Center, Aurora, CO
MAJ J. Ristaino, MSC, William Beaumont AMC, El Paso, TX
C, POT, Tripler Army Medical Center, HI

AC MTF, Executive Officer (1 req/3 completed)

LTC G. Plank, MSC, XO, MEDDAC, Fort Sheridan, IL
Executive Officer, Radar Health Clinic, Fort Meyer, VA
Administrator/XO, Dunham Army Health Clinic, Carlisle Bks, PA

AC MTF Professional Service Representative(s) (1 req/1 completed)

C, Professional Services, Noble Army Hospital, Fort McClellan, AL

AC MTF Logistics Representative(s) (1 req/2 completed)

COL J. Dolbier, MSC, Dir of Industrial Operations, FAMC, Aurora, CO
C, Logistics, Fox Army Hospital, Redstone Arsenal, AL

AC MTF Patient Admin Representative(s) (1 req/3 completed)

LTC L. Rowlette, MSC, C, DPA, Fitzsimons Army Medical Center, Aurora, CO
MAJ Valdez, MSC, C, Patient Admin, Ireland Army Hospital, Fort Knox, KY
CPT R. Comte, MSC, C, Patient Admin, McDonald Army Hospital, Ft Eustis, VA 23604

AC MTF Command Sergeants Major (2 req/2 completed)

CSM K. Glidewell, Fitzsimons Army Medical Center, Aurora, CO
CSM, Munson Army Hospital, Fort Leavenworth, KS

AC HSC HQ Representative(s) (1 req/1 completed)

COL R. Salmon, MSC, C, POT, HSC

AC OTSG Representative(s) (1 req/1 completed)

LTC S. Brown, MSC, Health Care Operations

Other (completed: 2)

C, Dept of Nutrition Care, Kenner Army Hospital, Fort Lee, VA
Chief Nurse, FORSCOM (AEMD), Fort McPherson, GA

TOTAL: 20 req/29 completed

# APPENDIX G

RESERVE COMPONENT (RC) RESPONDENTS

RC Advisor(s) to AHS (1 req/2 completed)

LTC D. McKnight, MSC, ARNG, Advisor to Commandant, AHS
MAJ D. Elder, MSC, USAR, Advisor to Commandant, AHS

RC Advisor to HSC (1 req/1 completed)

COL Gore, MSC, ARNG, Advisor, HSC

IMA (MOBDES) to HSC (1 req/1 completed)

COL T. Veach, MSC, MOBDES, HSC

IMA (MOBDES) to AC MTF/HQ (3 req/4 completed)

MG J. Harrell, MC, MOBDES, SGO
MG J. Simmons, MC, Special Assistant to The Surgeon General
COL H. Pratt, MSC, IMA, DPA, FAMC, Aurora, CO
CSM E. Ballard, MOBDES, FAMC, Aurora, CO

RC Commanders (4 req/7 completed)

COL R. Butz, MC, Cdr, 50th General Hospital, Seattle, WA
COL E. Crowell, MSC, Cdr, 99th CSH, Lancaster, PA
COL C. Haycock, MC, Cdr, 348th General Hospital, Folsom, PA
COL Jeves, MC, Cdr, 108th CSH, Philadelphia, PA
COL R. Stark, MC, Cdr, 322nd General Hospital, NJ
COL J. Stephenson, MC, Cdr, 117th CSH, San Antonio, TX
COL L. Stephenson, MC, Cdr, 361st Evac Hospital, Folsom, PA

RC Executive Officers (2 req/2 completed)

MAJ E. Lange, MSC, XO, 406th CSH, FAMC, CO
MAJ Yarter, MSC, XO/FIM, 5502nd USAH, FAMC, Aurora, CO

RC Dept of Nursing Representative(s) (3 req/6 completed)

COL H. Fisher, ANC, Chief Nurse, 406th CSH, FAMC, CO
COL H. Sagul, ANC, Chief Nurse, 4010th USAH (AUG), New Orleans, LA
LTC M. Montague, ANC, Chief Nurse, 309th Med Gp, MD
LTC F. Sullivan, ANC, Chief Nurse, 348th Gen Hosp, Folsom , PA
MAJ R. Burk, ANC, FIM, 6250th USAH, Tacoma, WA
CPT R. Burke, ANC, FIM, 92nd Field Hospital, MD

RC POT Representative(s) (4 req/4 completed)

MAJ J. Anderson, MSC, S-3, FTM, 316th Station Hosp, Harrisburg, PA
MAJ J. Byerly, MSC, SPO DISCOM, 28th ID, PA ARNG
MAJ R. McMasters, MSC, S-3 FTM, 338th Med Gp, Folsom, PA
CPT J. Morgan, MSC, S-3, FTM, 5502nd USAH, Aurora, CO

RC Command Sergeant(s) Major (1 req/1 completed)

CSM R. M. Sands, 5502nd USAH, FAMC, Aurora, CO

Other (completed: 1)

COL H. Pope, C, Prof Svcs, 5010th USAH, New Albany, IN

TOTAL: 20 req/29 completed

FOOTNOTES

[1]HSOP-SR Commander's Notes (CG HSC Bulletin 11-83), (Health Services Command, Fort Sam Houston, Texas 78234, November 1983), p. 4.

[2]Andre L. Delbecq, Andrew H. Van de Ven, and David H. Gustafson, Group Techniques for Program Planning: A Guide to Nominal Group and Delphi Processes (Glenview, Illinois: Scott, Foresman and Company, 1975), p. 89.

[3]Ibid, p. 106.

[4]Ibid, p. 89.

[5]Stephen Isaac and William B. Michael, Handbook In Research and Evaluation, (San Diego, California: Edits Publishers, 1983), p. 142.

[6]Eric C. Ludvigsen, "Elite Light Divisions Among Major Focuses in '85 Army Budget," ARMY 34 (April 1985); pp. 39-40.

[7]Ibid., p. 40.

[8]LTC Richard J. Berchin, MSC, and MAJ James Tierney, MSC. Letter, AFKA-ACA-MC-OI, HQ, 8th Medical Brigade, Fort Hamilton, New York City, New York, 30 September 1983, Subject: Two Year Training Plan - TY 85 and 86.

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Berchin, Richard J., LTC, and Tierney, James, MAJ. Letter, AFKA-ACA-MC-OI, HQ, 8th Medical Brigade, Fort Hamilton, New York City, New York, 30 September 1983, Subject: Two Year Training Plan - TY 85 and 86.

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LTC Dennis Patrick McKnight, ARNG, Advisor to the Commandant, AHS, Interview held on May 18, 1983.

Major David Hugh Elder, Jr., USAR, Advisor to the Commandant, AHS, Interview held on May 18, 1983.

Numerous interviews with AC and RC personnel concerning these issues during the period January 1980 to July 1982 while Chief, Medical Team, U.S. Army Readiness Group (ARMRII), Fort Indiantown Gap, Pennsylvania.

FORSCOM Regulation 350-2, Reserve Component Training, dated 1 October 1983.

AR 350-1, Army Training, 1 August 1981.

AR 350-17, NCO Development Program, 1 December 1980.

FM 25-2 (Test), How to Manage Training In Units, 23 June 1982.